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CUMBERLAND COUNTY COUNCIL

THE HEALTH OF CUMBERLAND 1967

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REPORT OF THE COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1967

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

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PREFACE

To the Chairman and Members of the County Council,

I have the honour to present my Annual Report on the Health of the County of Cumberland for the year 1967.

It continues to be clear to many working in community health that total patient care has to be rethought in the light of modern progress and modern ideas. A shake out of our ideas has to take place continuously if the patient is to have the care that he needs.

Medicine has always existed to meet basic needs of society, and as society changes so does, and indeed so must, medicine. We can all see the changes that are occurring in society and I, as a medical administrator, suggest that the main change that has occurred in medicine is the realisation that team work between and within the three branches of the National Health Service is taking over from the isolation and relative inefficiency of individual effort.

I have been impressed with the progress that has been made after eight years experience of the working of the attachment system, which has now led to the formation of family health care teams. The attachment system is now universally approved and applauded by all those with whom I have come in contact and who work in such a system. One of the reasons for the relatively smooth progression of this system of patient care in the community has been the fact that regular meetings of professional persons involved has been a powerful force to alter and indeed to temper attitudes to problems common to all parts of the health service. The first of such committees, the Local Maternity Liaison Committee, set up nearly a decade ago following the Cranbrook Committee recommendation to deal with the local problems of the maternal and young children group has been of great value and has been followed by other professional ad hoc committees dealing with psychiatric and geriatric problems in the community. The outstanding value of these professional committees has undoubtedly contributed greatly to changes in the professional attitude of all those attending.

The year just past has seen the near complete evolution of a new system of community medicine in Cumberland, wherein groups of family practitioners are starting to practice as teams and are supported by all the wide spectrum of care and help that is available from the local health and welfare authority. Several obstacles, however, have impeded the full development and I would be less than honest if I were to say that shortage of staff and money were not first in this list; a list which includes organisational difficulties associated with circumscribed local authority boundaries.

Community medicine can be defined as all those resources which are devoted to managing illness within the community of the well, and when one realises that less than 1% of the population are at any time in-patients in hospital, one could not be surprised that almost all of the sickness of the community be it chronic or transient, grave or slight, or only inconveniencing is in the world of the well. The main function of the hospitals is to provide diagnostic and curative facilities for patients sent to them from the community and to return those patients to the community as quickly and as well as possible. In addition to this function the hospitals still have and will continue to have a "care" rather than a "cure" function mainly in respect of some mentally disordered, handicapped, chronic sick and geriatric cases and others that cannot be adequately supported in the community.

The community itself is a most complicated system of human inter-relationships organised in countless interlocking systems, wherein the family, friends, neighbours and voluntary organisations interlock and interweave. Within the medical system in the community the general practitioner group with its attached staff is dominant.

The problem posed by change in community medicine is how to combine change with continuity, progress with tradition and the claims of legitimate authority with the individual's expectation of freedom.

Administratively it has been essential to ensure that progress such as has been made, and it has not been inconsiderable, was by

approval and agreement on all sides. I believe that here we are at the end of the beginning of complete integration of total patient care outside hospital by means of general practitioner led family care teams.

There are administrative difficulties which are raised by the concept of the family health care team. The first such difficulty relates to the disparity between local health authority boundaries and group practice areas. Some 95% of the population of Cumberland is served by doctors whose practice bases are situated within the administrative county and to whom are attached teams of nurses, social workers and others. The remaining 5% have doctors whose practices are based outside the administrative county, and I would hope that in the not too distant future fully developed nursing teams would exist also in overlapping authorities. Reciprocal services could then bring uniformity to the care of all county residents. Another administrative point concerns the increasing need of nursing supervision in the larger family health care teams where some six to nine nurses may be attached. Early steps to meet the situation are reported in the nursing section of this report, but its solution is not made easier by the present unfavourable financial climate.

Another trend in changing thought during the year has been the realisation that the medical officer of a local health authority (the non-clinical community physician) is the only doctor in the health service whose responsibility is completely community based and who has the organising experience, administrative ability and staff to ensure that teams of nurses and others are available to work as units under the clinical leadership of the general practitioner. The medical officer of health, as the non-clinical community physician, is the administrative medical organiser of patient care outside hospital, and indeed in the community generally, and it is he who must be satisfied that the overall distribution of staff is adequate for the needs of the community as a whole.

Thus, the concept of the medical officer of health of a local health authority with a department of community medicine inside a district general hospital and the formation of family health care teams in satellite health centres associated with the hospital is

now becoming more than a possibility for the future. If this happens there would seem to be a greater possibility that the community needs in the locality will be more adequately met, as they will be better known. Thus it is hoped that the next development could be the formation of a department of community medicine and epidemiology in the West Cumberland Hospital—a development which I think would be of the greatest value both to clinicians, working in hospitals and general practice, administrators in all branches of the service, and lastly, but by no means least, to patients and the general public in the area.

The year under review is one in which I can give a generally favourable report of the county's health record and I find that, broadly speaking, the statistics compare well with those of earlier years. In this respect I would particularly note that the infant death rate has never been lower and that there has been a relative absence of infection.

The net outward migration of population from the county, running at a figure of 3.3 Cumbrians per day with an increase of one Cumbrian per day of pensionable age, illustrates dramatically the difficulties in the field of health and welfare and challenges the efficiency of the whole health service in this northern county.

However, team work, which I have mentioned previously in this foreword, exists to an extremely high degree in the public health service and the work of all in the department during the year has been one of susained effort of the highest standard.

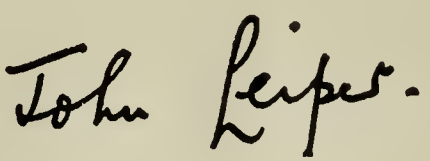
Since my last Report, Miss I. Mansbridge, Superintendent Nursing Officer, and Mr. S. Hodgson, Welfare Services Officer, have retired. Both had given excellent service to the County Council and had carried heavy responsibilities more than adequately. In addition, in the last years in post they had both been associated with forward looking schemes and actions. They can look back with pride to their undoubtedly fine achievements. Mr. J. Fisher has also retired and as an administrative officer his fund of knowledge and experience has been greatly missed.

This Report indicating as it does on almost every page the changing thoughts in regard to total patient care in this county, would be neither complete nor accurate if I were not to thank my colleagues in the Local Medical Committee under the chairmanship of Dr. H. Nelson, the members of the Special Area Committee whose chairman is Mr. R. S. Venters, and the chairmen and members of the East and West Cumberland Hospital Management Committees with their medical, nursing and administrative staffs. Throughout our discussions, at times with opposing views being put forward, I have constantly felt that an increasing sense of functional if not administrative unity in the health service was emerging with a great measure of agreement on hospital and community medicine for the future.

Finally, my thanks go out to the Chairman of the Health Committee for her constant support, advice, and direction, and to the staff of the department for consistently superbly good work in a year of such fine service and progress.

I remain, ladies and gentlemen,

Your Obedient Servant,



County Health Department,
11, Portland Square,
Carlisle.
Telephone. No. Carlisle 23456

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and County Welfare Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Area Medical Officers—

J. L. Hunter, M.B., Ch.B., D.P.H., Western Area Medical Officer; Medical Officer of Health, Workington Borough.

F. S. Rogers, M.B., Ch.B., D.P.H., Northern Area Medical Officer; Medical Officer of Health to Border Rural District.

S. Smith, M.B., Ch.B., D.P.H., Southern Area Medical Officer; Medical Officer of Health, Whitehaven Borough and Ennerdale Rural District.

Assistant County Medical Officers—

J. E. Ainsworth, M.B., Ch.B.

E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. and H., (also Medical Officer of Health, Maryport Urban District)

D. H. Chowdhury, M.B., B.S., D.P.H., D.I.H., (also Medical Officer of Health, Penrith Rural District and Penrith Urban District).

J. E. M. Garland, M.B., Ch.B., D.P.H., (also Medical Officer of Health, Wigton Rural District).

A. Hargreaves, M.B., Ch.B., D.P.H., (Deputy Western Area Medical Officer, Medical Officer of Health, Cockermouth Rural and Urban Districts, Keswick Urban District).

J. R. Hassan, M.B., Ch.B., D.Obst., R.C.O.G., (also Medical Officer of Health, Alston Rural District and General Practitioner).

H. M. Marks, M.B., Ch.B.

M. Timperley, M.B., Ch.B.

K. R. Walker, M.B., Ch.B.

DENTAL

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Western Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

A. B. Gibson, B.D.S.

*Mrs. A. Osuhor, B.D.S.

F. H. Jacobs, L.D.S.

I. H. Parsons, L.D.S.

A. R. Peck, L.D.S.

A. M. Scott, L.D.S.

WELFARE SERVICES

Welfare Services Officer—

N. Froggatt.

Deputy Welfare Services Officer—

I. Duthie, C.S.W., D.P.A.

Social Welfare Officers—

Northern Area

Miss E. A. Welch, A.A.P.S.W., Senior Welfare Officer.

M. Steels.

I. H. Moffet, C.S.W.

M. H. Payne.

*W. H. Robinson.

Western Area

Miss E. F. Hall, Senior Welfare Officer.

B. Reeves.

A. Davidson, R.M.N., S.R.N.

A. Irving.

T. Hetherington.

Miss D. Tindall, Welfare Assistant.

Southern Area

A. F. Barlee, B.Sc. Econ., Senior Welfare Officer.

J. Allison.

R. Daley.

C. Harrison.

J. M. Ruddick, C.S.W.

Miss C. Marshall, Welfare Assistant.

* Part-time.

Manager/Matron of Residential Accommodation—

Mrs. M. Beresford, Grisedale Croft, Alston.

Mrs. M. Campbell, Castle Mount, Egremont.

Mrs. M. Hinde, Post Psychotic Hostel, Fairview, Bransty, Whitehaven. (Acting Warden).

Mrs. N. Johnson, S.E.N., Richmond Park, Workington.

Miss E. T. Durkan, The Croft, Kirksanton.

Miss B. Edgar, Grange Bank, Wigton.

Mrs. M. M. Guy, S.R.N., Highfield House, Wigton.

Mrs. A. Hill, S.R.N., Station View House, Penrith.

Mrs. M. Melville. Moot Lodge, Brampton.

Mrs. H. S. Milnes, Derwent Lodge, Papcastle.

Miss A. G. Ross, S.R.N., Parkside, Maryport.

Miss A. Wright, Garlieston, Whitehaven.

Mrs. R. Wilson, S.R.N., Brackenthwaite, Whitehaven.

Miss V. Woodman, S.R.N., The Towers, Skinburness.

Miss E. McCormick, Park Lodge, Aspatria.

Home Teachers for the Blind—

Miss J. Burgess.

Miss L. D. Fraser.

Mrs. G. Mossop.

Miss M. Shuttleworth.

Training Centre Supervisors—

J. J. Lace, Dip. N.A.M.H., Adult Training Centre, Distington.

Miss A. Love, Dip. N.A.M.H., Dip. T.C.T.M.H., Junior Training Centre, Whitehaven.

Miss G. L. Lister, Dip. N.A.M.H., Dip. T.C.T.M.H., S.E.N., Junior Training Centre, Wigton.

Consultant Psychiatrists (part-time) seconded from Newcastle upon Tyne Regional Hospital Board—

T. R. Burgess, M.R.C.S., L.R.C.P., D.P.M.

T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

NURSING STAFF

Superintendent Nursing Officer—

Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—

Vacant.

Area Nursing Officers—

Miss J. M. Crossfield, S.R.N., Q.N., H.V.Cert., Western Area.

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert., Southern Area.

Miss J. M. Till, S.R.N., S.C.M., H.V.Cert., Q.N., D.T.N., Northern Area.

Audiometricians—

Miss J. Gill.

Miss A. Jackson.

Chiropodists—

G. H. Thomas, M.Ch.S., S.R.Ch.

W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N.

Mrs. H. Coulson, M.Ch.S., S.R.Ch.

Mrs. D. E. Smart, M.I.C.Ch., S.R.Ch.

Mrs. G. Garrett, M.Ch.S., S.R.Ch.

Mrs. J. Glaister, M.Ch.S., S.R.Ch.

Orthoptists—

*Mrs. G. Richardson, D.B.O.

*Mrs. J. Scott, D.B.O.

Physiotherapists—

*Mrs. P. P. Bratt, M.C.S.P.

*Mrs. M. Sivewright, M.C.S.P.

Speech Therapists—

Mr. M. S. Beattie, L.C.S.T.

Mrs. E. M. Blacklock, L.C.S.T.

*Miss E. B. Moon, L.C.S.T.

*Mrs. S. Latimer, L.C.S.T.

*Mrs. J. Stone, L.C.S.T.

County Ambulance Officer—

M. F. Smith, F.I.A.O.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

* Part-time

NORTHERN AREA

FAMILY HEALTH CARE TEAMS

DECEMBER, 1967

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
Dr. J. R. Hassan) Dr. P. M. Beckingham) Alston	Mrs. E. M. Walton Aux: Mrs. A. Davidson	Mrs. E. M. Walton	Miss E. A. Lockhart
Dr. A. K. Rankin) Dr. A. M. Rankin Aspatria.	Miss J. Higginbottom	Miss J. Higginbottom	Miss C. M. Bannan
Dr. A. C. Beeby Aspatria	Miss J. Higginbottom	Miss J. Higginbottom	Miss C. M. Bannan
Dr. W. F. H. Coulthard Aspatria	Miss J. Higginbottom	Miss J. Higginbottom	Miss C. M. Bannan
Dr. H. P. Nelson) Dr. W. J. Lush) Dr. R. E. D. Nelson) Dr. J. C. Burn) Dr. I. J. Clark) Brampton	Miss B. M. Wesson Mrs. F. Gaskin	Mrs. F. M. Hurst	Miss E. Tongue Miss B. Knibbs
Dr. M. I. Cox) Dr. P. T. Vale) Caldbeck	Miss A. Bowler	Miss A. Bowler	Miss A. Bowler
Dr. W. P. Hayne) Dr. H. J. Bradley) Dalston	Mrs. M. E. Wilde Mrs. M. Thom	Mrs. M. E. Wilde Mrs. M. Thom	Miss P. B. Simpson
Dr. N. W. Cameron High Hesket	Miss J. R. N. Byres	Miss J. R. N. Byres	Mrs. C. M. Sinclair
Dr. N. C. F. Milne Kirkoswald	Miss J. R. N. Byres	Miss J. R. N. Byres	Mrs. M. McCredie

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
Dr. D. A. McDonald Dr. R. A. Maxwell Kirkbride	Miss A. A. Cockton	Miss A. A. Cockton	Miss I. Arnott
Dr. R. A. Forrester Longtown	Miss M. Keenan Mrs. F. M. Hurst	Miss M. Keenan Mrs. F. M. Hurst	Miss M. Butler
Dr. G. M. Ingall Longtown	Miss M. Keenan Mrs. F. M. Hurst	Miss M. Keenan Mrs. F. M. Hurst	Miss M. Butler
Dr. H. Hutton Dr. R. M. Yule Silloth	Miss G. Jobson	Miss G. Jobson	Mrs. M. D. Dixon
Dr. W. Hetherington Dr. D. A. Nisbet Wetheral	Miss M. Weightman	Mrs. M. Dobson	Mrs. M. Dobson
Dr. T. M. Doland Dr. G. A. H. Jones Dr. N. Gray Wigton	Mrs. D. Lancaster Mrs. M. Hope	Mrs. D. Lancaster	Miss E. Mercer
Dr. F. C. Edington Dr. H. C. Barr Dr. I. M. Johnstone Dr. G. F. Lewis Penrith	Mrs. E. J. Relph Mrs. G. Nixon	Mrs. G. Nixon	Miss E. M. Chalkey Miss J. Gibson
Dr. G. H. Kilgour Dr. C. H. Thomson Penrith	Mrs. I. Penn Mrs. V. Lamb	Mrs. I. Penn	Miss A. Dixon
Dr. K. Todd Dr. J. B. Scott Dr. I. O. Miller Penrith	Miss K. Winter Mrs. E. Plant	Miss K. Winter	Miss E. Henderson
Dr. K. Gillow Dr. T. Mooney Dr. T. Gardner	Mrs. E. M. Stafford (Surgery Nurse)		

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
Dr. G. Raitt) Dr. J. F. McKellican) Dr. A. Backman) Carlisle			
Dr. G. M. Jolly) Dr. W. C. Menzies) Dr. W. P. Honeyman) Dr. N. C. Frame) Carlisle.	Mrs. J. A. Branthwaite		
Dr. J. D. Ogilvie) Glenridding.) North Westmorland	Mrs. M. J. Mathews	Mrs. M. J. Mathews	Mrs. M. J. Mathews

The following act as relief nurses, as and when required:—
Mrs. K. M. Bell, Mrs. L. Bell, Mrs. J. Dickinson, Miss V. Dodgson, Mrs. M. Jackson, Mrs. M. Judson, Mrs. D. Patterson, Mrs. D. Poole, Mrs. E. E. Rome, Mrs. D. M. Scoon, Mrs. P. E. White.

SOUTHERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER, 1967

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
WHITEHAVEN AREA:			
Dr. V. C. J. Harris Dr. M. C. Nicolson Dr. R. N. Galloway Dr. B. T. Higgins	Mrs. I. Routledge Mrs. H. Egan Mrs. A. Keanan	Mrs. M. Ainsworth	Mrs. S. Crellin Mrs. A. W. Lynn
Dr. R. W. Chalmers Dr. A. P. Timney	Mrs. M. West	Mrs. M. Ainsworth	Mrs. I. M. Alcock
Dr. J. Gilmour	Miss O. G. Coates	Mrs. M. Ainsworth	Mrs. I. M. Alcock
Dr. H. A. Fleming Dr. J. G. Dickson Dr. E. Graham	Miss J. Woodend	Mrs. M. Ainsworth	Miss A. Singleton
Dr. N. L. Burrell Dr. R. C. McFarlane	Mrs. E. Brannan	Mrs. M. Ainsworth	Mrs. A. Petch
Mr. W. Anderson — Male Nurse — Works with ALL Whitehaven Practices.			
ENNERDALE AREA:			
Dr. H. Calder Dr. J. Sharp	Miss J. A. G. Hardie	Miss J. A. G. Hardie	Miss J. A. G. Hardie
Dr. W. G. McKay Dr. C. Donald Dr. E. Johnston Dr. T. S. Jones	Miss H. Spencer	Miss M. Proctor	Mrs. I. J. Smith
Dr. W. T. Hunter Dr. J. N. Edgley Dr. P. Sutherland	Miss V. Batty Mrs. M. T. Toole	Miss V. Batty Miss E. M. Miller	Miss M. E. Gibson Miss R. Sheppard

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
Dr. A. S. Smith Dr. L. Henry	Mrs. F. Corkhill	Miss V. Batty	Miss E. Crosby
Dr. E. Braithwaite Dr. J. W. Strain	Mrs. A. Geli	Miss V. Batty	Miss P. Walsh
Dr. J. Louden Dr. J. W. Jago Dr. J. M. Kirk Dr. A. M. Smith	Miss D. D. James Mrs. Speed-Andrews Mrs. J. A. Capp Mrs. E. Gallantry Mrs. M. Marshall	Miss D. D. James Mrs. M. Marshall	Miss D. D. James Mrs. M. Marshall
MILLOM AREA:			
Dr. A. E. Jackson Dr. K. Flynn Dr. M. J. Leverton Dr. P. M. Taylor	Miss M. G. Beattie Mrs. I. Booth Mrs. M. Wilson Mrs. S. E. Troll	Miss M. G. Beattie Mrs. I. Booth	Mrs. I. E. Bowe Mrs. A. Donald

The following act as relief nurses, as and when required:—
Mrs. M. Bridges, Mrs. A. Holmes, Mrs. S. Pierce, Mrs. V. Moore, Mrs. A. Rae.

WESTERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER, 1967

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
COCKERMOUTH AREA			
Dr. T. Fletcher Dr. E. B. Herd	Miss A. I. Kirk Miss M. Musgrave Mrs. V. Sherwood	Miss A. Kirk Miss M. Musgrave	Mrs. M. Lythgoe Miss M. Reynolds
Dr. A. G. Abraham	Mrs. K. Lytollis	Miss A. Kirk Miss M. Musgrave	Miss M. Reynolds
Dr. R. J. M. Irvine	Mrs. J. V. Clark	Mrs. J. V. Clark	Miss M. Reynolds
KESWICK AREA			
Dr. J. A. Harrow	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. Mitchell	Miss A. B. Bradford	Miss A. B. Bradford	Miss M. Casey
Dr. T. Donaldson	Mrs. B. P. Ashe	Miss A. B. Bradford	Mrs. A. E. Campbell
Dr. I. F. Smith	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
MARYPORT AREA			
Dr. J. D. H. Bird Dr. S. A. W. Rattrie Dr. K. Longstaff Dr. B. J. Havard Dr. F. W. Clark Dr. C. M. Yule	Miss A. Chadwick Miss O. Pickering Mrs. C. M. Gate Mrs. E. Beckwith Mrs. A. Irving	Miss O. Pickering Miss A. Chadwick Mrs. C. M. Gate	Miss S. Twigg Mrs. M. Hedworth

General Practitioners to whom attached	Home Nurses	Midwives	Health Visitors
WORKINGTON AREA			
Dr. R. E. Fletcher Dr. R. H. Fletcher Dr. W. H. Fletcher Dr. A. Craig	Mrs. R. Stephenson	Mrs. M. K. Tunstall	Miss A. Jackson
Dr. D. N. Fitzgerald	Mrs. M. I. Lowis	Mrs. M. K. Tunstall	Mrs. M. Hewitson
Dr. N. McKerrow Dr. P. I. Rutherford Dr. M. O. Sime	Miss M. Young Mrs. J. M. Brown	Mrs. M. K. Tunstall	Miss E. J. Surtees Mrs. J. A. Graham
Dr. J. Pavey-Smith Dr. I. R. McLeod	Mrs. M. Hamilton	Mrs. A. Maguire	Mrs. B. L. Goodson
Dr. C. Robinson Dr. J. Prentice	Mrs. L. Messenger Mrs. J. Palin	Mrs. A. Maguire	Miss F. Davies
Dr. G. M. Thomas	Mrs. M. I. Lowis	Mrs. A. Maguire	Mrs. D. R. Bari
Dr. R. N. R. Grant	Mrs. M. I. Lowis Mrs. M. Swinburne	Mrs. A. Maguire	Mrs. D. R. Bari
	Mr. T. O. M. Holmes and Mr. T. G. Carter	Male Nurses—work with all general practitioners	

The Following act as relief nurses, as and when required:—
Mrs. I. E. Barnes, Mrs. P. Holdsworth, Mrs. M. Mitchell, Mrs. S. E. Scott, Mrs. M. M. Swinburn, Mrs. E. Swindle, Mrs. M. B. White.

ADMINISTRATION

The arrangements for the administration of the health and welfare services are, briefly, that matters of policy, finance and training are dealt with centrally, while day-to-day management is delegated to the three Area Health Committees and their Area Medical Officers. In addition to receiving the reports of the Area Committees the parent Committee receives reports from the Joint Health and Education Committee, which deals with matters pertaining to the school health service and health education in general; from the Joint Committee consisting of members appointed by the County Council and Carlisle Borough Council to look after the affairs of the Cumberland and Carlisle Workshops for the Blind; and from the central General Purposes Sub-Committee which deals with matters not related to the functions of existing standing sub-committees, the affairs of the ambulance service and such matters of policy as may be referred to it for detailed study.

To foster closer liaison between the branches of the health service there is a Health and Medical Services Liaison Group which meets twice a year to discuss the effects of policy decisions and actions by one branch or the others. The aim, of course, is to discuss these matters while the projects are still in their early planning or even pre-planning stage. The group is mostly, but not entirely, professional and has representation from this authority, the Carlisle authority, the Special Area Committee of the Regional Hospital Board, Cumberland Executive Council, Carlisle Executive Council and the Cumberland and Carlisle Local Medical Committees.

Health and Welfare liaison is also furthered by the periodic publication of bulletins to keep general practitioners in touch with the work of the department.

In addition, I or my deputy attend meetings of the West Cumberland Hospital Management Committee, Garlands Advisory Committee and Local Maternity Liaison Committees, while I attend meetings of the Special Area Committee. These contacts all help considerably to overcome the separation of services which present legislation imposes but I do feel that the County Health

Committee should have a representative on the Special Area Committee. That body makes policy decisions which can have great impact on the local authority services and I feel that there should be someone with full voting rights to make clear the authority's position.

The staffing situation regarding District Medical Officers of Health, who are also Assistant County Medical Officers is beginning to give cause for concern. Two posts with small district councils are vacant and another may shortly become vacant on a retirement. There seems little prospect of filling any of these posts and the introduction of a more flexible scheme to make better use of the services of Medical Officers of Health is being investigated.

On the debit side I must, however, report increasing difficulty in recruiting dental officers, a relatively new situation in Cumberland. After years with a full establishment it seems almost catastrophic to be reduced to seven full-time and one part-time dentist against an establishment of eleven, a situation which I know many authorities have endured for years. Geography does, however, act particularly unfavourably in this county when there is a shortage of staff.

It is a pleasant change to report an improvement in the staffing situation so far as speech therapists and orthoptists are concerned. For the first time in many years there is a full establishment of speech therapists and, in addition, two young ladies are now training under the authority's scholarship school which grants them £450 a year plus tuition and examination fees and travelling expenses connected with their courses. In return they undertake to come back to Cumberland to work for at least two years. Their services will certainly be required, even although the establishment is already filled, because there is an increasing demand for speech therapy in hospitals which will be met by the secondment of county staff.

Also for the first time in many years the authority has a full-time orthoptist in addition to the two part-time members of staff. She is the first product of the orthoptic scholarship scheme, which is similar to that for speech therapists.

The introduction of a system of area administration with considerable delegation is, I believe, continuing to prove its worth and the following table gives some details of the individual areas. It is now difficult to imagine how, in this widely scattered authority, a centralised system of administration could have continued to administer efficiently the rapidly expanding services.

THE ADMINISTRATIVE AREAS OF THE COUNTY

Area	Area Medical Officer	Districts covered	Total Acreage	Total population	Births in 1967	Child Welfare Centres	Child Welfare Attendances	Training Centres Centres	Training Centres Places	Part III Accomm. Homes	Part III Accomm. Places	Part III Accomm. Sup. Ind. Places
Northern	Dr. F. S. Rogers, 13 Portland Square, Carlisle.	Alston R.D. Border R.D. Penrith R.D. Penrith U.D. Wigton R.D.	612,000	77,160	1,137	15	9,889	1	45	7	205	150
Western	Dr. J. L. Hunter, Stoneleigh, Park End Road, Workington.	Cockermouth R.D. Cockermouth U.D. Keswick U.D. Maryport U.D. Workington M.B.	173,000	73,800	1,200	9	8,821	1	50	3	94	88
Southern	Dr. S. Smith, Flatt Walks, Whitehaven.	Ennerdale R.D. Millom R.D. Whitehaven M.B.	182,000	74,140	1,264	9	13,710	1	75	4	128	24

GENERAL STATISTICS AND SOCIAL CONDITIONS OF THE AREA

I am including this year in my report some comments on the general statistical information for the county for 1967. The main body of statistical tables which follow are related to these comments.

Population

The Registrar General's mid-year estimate of population for the Administrative County for 1967 showed 160 fewer persons than 1966. The natural increase (births less deaths) was 1,049 which indicates a total outward migration of 1,209 persons, or 3.3 persons per day. This outward migration has been evident since 1964 and the following table shows that the loss to the county since that date has been 4175 persons.

Year	R.G's. Mid-Year Estimate of population	Natural Increase Births less Deaths	Nett migration (Persons) In	Out	Nett migration Rate per day In	Out
1961 ...	221,460	—	—	—	—	—
1962 ...	223,330	1362	508	—	1.4	—
1963 ...	224,630	1151	1419	—	0.4	—
1964 ...	225,690	1477	—	417	—	1.1
1965 ...	225,570	1210	—	1330	—	3.7
1966 ...	225,260	909	—	1219	—	3.4
1967 ...	225,100	1049	—	1209	—	3.3

High unemployment rates and lack of opportunity for young people are the probable reasons for this migration, and although the migrating age groups cannot be precisely determined without the full census figures, there is sufficient evidence in the comparison of the 1961 census and the 1966 sample census figure (published this year) to indicate that most of the migration in the intervening period was amongst those who were aged between 15 and 24 in 1961.

Some indication of the number involved can be seen in the following table where the age group mentioned is seen to have suffered a total overall loss of 5417 persons:

1961 Census		1966 Sample Census		Overall
Age Group	No.	Age Group	No.	loss
15-19	16,262	20-24	11,990	4,272
20-24	13,285	25-29	12,140	1,145

There is also evidence to indicate that the overall loss in this particular age group includes quite a high proportion of able young people proceeding out of the county for advanced further education. The proportion of these who return to employ their skills in Cumberland is comparatively small. It will be clear that such a situation represents a substantial loss of both ability and persons. This must ultimately make for a significant imbalance in the population with an increasing proportion of elderly people remaining behind and making continually growing demands upon health and welfare services.

Vital Statistics

Births

The number of births have again fallen from 3670 in 1966 to 3601 in 1967 and has lowered the birth rate (number of births per 1,000 total population) to 16.0 the lowest peace-time rate since those immediately preceding the war. A graph showing the comparison of national and county birth rates is included in the main body of statistical tables and it is notable that while both rates are decreasing, probably affected to some degree by the low birth rates of the 1930's, there is a more marked decrease in the county rate which I associate with the outward migration of the 15-24 age group of 1961 referred to earlier.

There was a rise in the number of illegitimate births; these increased from 215 in 1966, to 236.

The number of stillbirths was 70 giving a rate of 19.1 still-births per 1,000 live and stillbirths. This is reflected in the high perinatal mortality rate of 29.4 stillbirths and deaths under 1 week, per 1,000 live and stillbirths. The perinatal mortality rate for England and Wales for 1967 is 25.4 The large number of stillbirths occurring in Cumberland in 1967 has been investigated in some detail. 75% of the stillbirths have been associated with prematurity but no other factors could be related to the sharp increase in 1967.

The study of all perinatal deaths, case by case, continues in both East and West Cumberland under the auspices of the local maternity liaison committees. In West Cumberland this is undertaken by a team of the hospital consultants concerned, and in East Cumberland an annual report is submitted to the maternity liaison committee, summarising information on the perinatal deaths of the previous year. A small sub-committee considers the analysis and presentation of these facts and how this can be improved. In East Cumberland considerable interest has centred on the role of prematurity in connection with perinatal deaths. All cases with this particular association are studied in greater detail. Detailed statistical data on perinatal deaths and on prematurity are shown in the Midwifery section.

Maternal Mortality

The maternal mortality rate is 0.5. This represents 2 deaths during 1967 associated with pregnancy, neither of which, I am glad to say, are of the kind which reflect upon the general standard of maternity services or which indicate any element of lack of care. One concerned a 30 year old mother, with a gross congenital deformity of the spine and chest, who suffered an abortion. Because this was incomplete a small operation under general anaesthetic was necessary. Unhappily the patient collapsed and died after the operation. The other was a case of a mother of 29 years with long standing heart disease whose pregnancy was very much a calculated risk. It became necessary to undertake cardiac surgery during the pregnancy and the mother did not survive this

eath Rate

1967 saw the record of the lowest death rate ever in the unty, namely 11.3 deaths per 1,000 total population. Causes death in 1967 by administrative areas of the county are shown the following tables. The main causes of death are shown graphic form on the histogram inserted in the statistical in-rmation which follows. An analysis of the deaths of Cumber-nd residents shows that the number of deaths in the county has mained constant over the period 1940-67. The death rate over is same period shows a slight overall decrease, but this is due the increase in population.

Comparison of the main causes of death during the period, xpressed as a percentage of the total deaths, shows some interest-ng changes as illustrated by the histogram on Main Causes of Death. The most significant trend observed is the increase in eaths from heart and circulatory diseases by approximately 13% f the total deaths. Since 1952 heart and circulatory diseases have ccounted fairly constantly for 40% of the total deaths.

On examining the number of deaths caused by all heart liseases (but excluding other circulatory diseases) it is interesting o note that Cumberland has a death rate some 10% higher than he figure for England and Wales. A study of previous years, ack to 1954, shows that then Cumberland's death rate from all eart diseases was near to 20% above that for England and Wales. Thus this difference persists but is less accentuated than it was hen. When such an interesting phenomenon is observed, it is a nuch more difficult task to discover the underlying causes.

Relating to the data shown on the histogram other notable increases are evident in "vascular lesions of the nervous system" and "malignant diseases". Each shows an increase of 5% of the total. These three causes of death now account for 73% of all deaths in the county.

Successful progress in the treatment of tuberculosis shows in the virtual elimination of this disease as a main cause of death. Deaths from malignana diseases have increased by almost 50% over the period represented in the histogram, and a solemn reflec-tion is the contribution which cancer of the lung has made to this feature.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054 acres.
Rateable Value (April 1st, 1967) — £7,447,941.
Estimated Product of 1d. Rate (1967-68) — £29,829.
Population (Census, 1951) — 217,540
Population (Census, 1961) — 223,202
Population (1967 Mid-Year Estimate) — 225,100.

Live Births — Number	3,601
Rate per 1,000 population	16.0
Illegitimate Live Births per cent of total births ...	6.6
Still Birth — Number	70
Rate per 1,000 total live and still births	19.1
Total Live and Still births	3,671
Infant Deaths (Deaths under 1 year)	61
Infant Mortality Rates—	
Total Infant Deaths per 1,000 total live births ...	16.9
Legitimate Infant Deaths per 1,000 total legitimate births	16.0
Illegitimate Infant Deaths per 1,000 total illegitimate births	29.7
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	11.4
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births)	10.6
Perinatal mortality rate (Still births and Deaths under 1 week combined per 1,000 total live and still births)	29.4
Maternal Mortality (including abortion) — Number of deaths	2
Rate per 1,000 total Live and Still births	0.5

A more detailed analysis of the above figures is given overleaf

	Male	Female	Total	Urban District	Rural Districts	Admin. County	Eng. & Wales (Prov.)
LIVE BIRTHS—							
Legitimate ...	1,729	1,636	3,865				
Illegitimate ...	122	114	236				
	1,851	1,750	3,601				
Birth rate per 1,000 population ...				17.0	15.3	16.0	17.2
STILL BIRTHS—							
Legitimate ...	29	32	61				
Illegitimate ...	6	3	9				
	35	35	70				
Still birth rate per 1,000 total births				17.9	20.0	19.1	14.8
DEATHS—							
All causes ...	1,323	1,229	2,552				
Death rate per 1,000 population ...				11.4	11.3	11.3	11.2
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	28	26	54				
Illegitimate ...	3	4	7				
	31	30	61				
Total infant deaths per 1,000 total live births				16.3	17.4	16.9	18.3

District	BIRTHS						
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor	Stillbirths	Stillbirth Rate
URBAN DISTRICTS—							
Cockermouth	108	5	113	18.1	1.00	1	8.8
Keswick	61	7	68	15.6	1.15	—	—
Maryport	212	9	221	18.2	0.96	6	26.4
Penrith	154	15	169	15.5	1.00	2	11.7
Whitehaven	453	31	484	17.9	0.93	9	18.5
Workington	440	42	482	16.1	1.00	10	20.7
Aggregate	1,428	109	1,537	17.0	0.98	28	17.5
RURAL DISTRICTS—							
Alston	25	1	26	12.6	1.25	2	71.4
Border	376	26	402	13.0	1.12	5	12.2
Cockermouth	302	14	316	14.9	1.02	8	24.7
Ennerdale	526	36	562	17.5	0.99	9	15.8
Millom	203	15	218	14.5	1.08	2	9.1
Penrith	169	10	179	15.6	1.07	7	37.0
Wigton	336	25	361	16.5	1.05	9	24.3
Aggregate	1,937	127	2,064	15.3	1.05	42	20.0
Administrative County	3,365	236	3,601	16.0	1.02	70	19.4

ID POPULATION IN THE YEAR 1967

DEATHS			INFANT MORTALITY										
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	Estimated Mid-year population
61	9.8	1.08	3	3	—	2	2	26.6	17.7	17.7	3	26.3	6240
73	16.8	0.80	2	1	1	2	2	29.4	29.4	29.4	2	29.4	4350
146	12.0	1.19	4	4	—	3	3	18.1	13.6	13.6	9	39.7	12150
131	12.0	0.95	1	—	1	—	—	5.9	—	—	2	11.7	10880
298	11.0	1.21	8	7	1	7	7	16.5	14.5	14.5	16	32.5	27050
325	10.9	1.19	7	7	—	5	4	14.5	10.4	8.3	14	28.5	29900
1,034	11.4	1.13	25	22	3	19	18	16.3	12.4	11.7	46	29.4	90570
25	12.1	0.84	—	—	—	—	—	—	—	—	2	71.4	2060
410	13.3	0.87	9	8	1	7	6	22.4	17.4	14.9	11	27.0	30890
214	10.1	1.09	4	3	1	1	1	12.7	3.2	3.2	9	27.8	21160
327	10.2	1.21	15	13	2	9	9	26.7	16.0	16.0	18	31.5	32030
126	8.4	1.29	2	2	—	2	1	9.2	9.2	4.6	3	13.6	15060
114	9.9	1.05	1	1	—	1	1	5.6	5.6	5.6	8	43.0	11480
302	13.8	0.94	5	5	—	2	2	13.9	5.5	5.5	11	29.7	21850
1.518	11.3	1.04	36	32	4	22	20	17.4	10.7	9.7	62	29.4	134530
2.552	11.3	1.06	61	54	7	41	38	16.9	11.4	10.6	108	29.4	225100

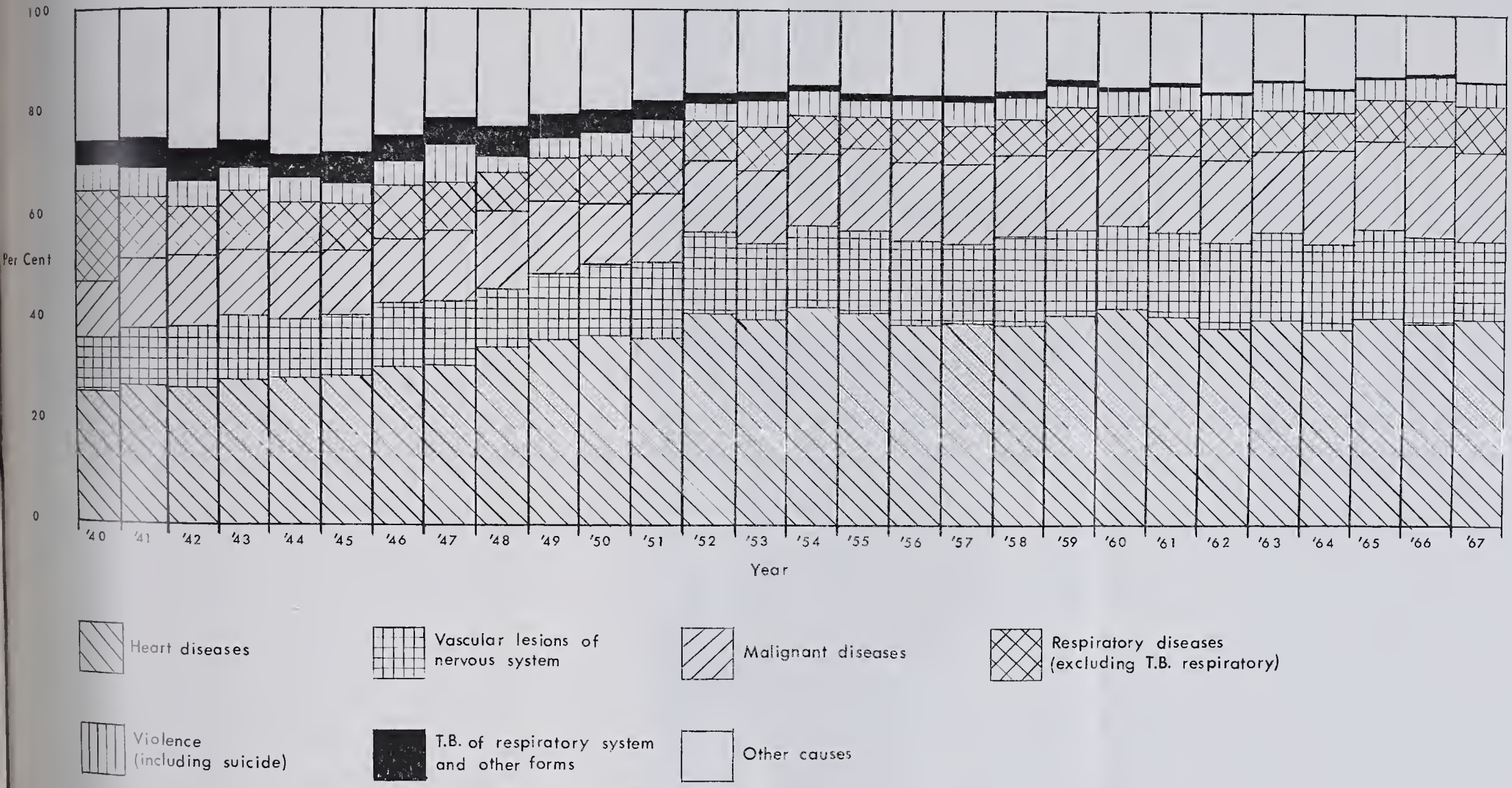
Cause of Death	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.
All Causes	2,552	61	73	146	131
1. Tuberculosis, Respiratory	5	—	—	—	1
2. Tuberculosis, Other	—	—	—	—	—
3. Syphilitic Disease	2	—	—	—	1
4. Measles	—	—	—	—	—
5. Other Infective and Parasitic diseases ...	5	—	—	1	—
6. Malignant neoplasm, stomach	81	4	4	5	3
7. Malignant neoplasm, lung bronchus ...	97	2	4	6	4
8. Malignant neoplasm, breast	34	2	3	1	3
9. Malignant neoplasm, uterus	20	—	—	1	3
10. Other malignant and lymphatic neoplasms	216	3	9	15	16
11. Leukaemia, Aleukaemia	14	1	—	1	—
12. Diabetes	28	—	—	6	—
13. Vascular Lesions of Nervous System ...	392	12	11	23	14
14. Coronary Disease, Angina	586	16	17	23	30
15. Hypertension with Heart Disease	33	—	1	3	3
16. Other Heart Disease	301	2	14	18	20
17. Other Circulatory Disease	115	3	2	9	8
18. Influenza	4	—	—	1	—
19. Pneumonia	99	3	1	1	1
20. Bronchitis	88	—	1	8	5
21. Other Diseases of the Respiratory System	32	1	—	1	—
22. Ulcer of Stomach and Duodenum ...	20	—	—	3	1
23. Gastritis, Enteritis and Diarrhoea ...	10	—	—	—	—
24. Nephritis and Nephrosis	10	—	—	—	1
25. Hyperplasia of Prostate	10	—	—	—	—
26. Congenital Malformations	13	1	—	1	—
27. Other Defined and Ill defined diseases ...	215	8	3	10	13
28. Motor vehicle accidents	44	—	1	2	—
29. All other accidents	67	3	2	7	4
30. Suicide	11	—	—	—	—
31. Homicide and Operations of War ...	—	—	—	—	—

TRATIVE AREAS (1967)

Whitehaven M.B.	Workington M.B.	Aggregate of U.D's.	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D's.
298	325	1,034	25	410	214	327	126	114	302	1,518
2	—	3	1	—	—	1	—	—	—	2
—	—	—	—	—	—	—	—	—	—	—
—	—	1	—	1	—	—	—	—	—	1
—	—	—	—	—	—	—	—	—	—	—
2	—	3	—	—	—	2	—	—	—	2
8	6	30	1	9	7	11	3	3	17	51
10	18	44	1	16	10	9	4	2	11	53
7	1	17	1	3	2	5	—	1	5	17
3	2	9	—	1	4	3	1	—	2	11
19	30	92	1	29	17	20	12	15	30	124
2	2	6	—	1	2	1	1	1	2	8
5	2	13	—	—	1	3	3	2	6	15
50	43	153	3	72	24	46	20	15	59	239
62	84	232	5	91	55	76	35	28	64	354
3	4	14	—	7	7	3	—	—	2	19
21	38	113	4	68	23	37	11	21	24	188
10	15	47	—	22	8	17	3	5	13	68
—	—	1	—	—	—	1	—	—	2	3
14	16	36	1	17	12	19	6	1	7	63
10	16	40	1	9	7	10	6	4	11	48
3	2	7	—	6	3	6	4	3	3	25
2	3	9	—	3	1	4	1	—	2	11
3	—	3	—	2	1	2	—	1	1	7
—	2	3	—	2	2	1	—	—	2	7
2	1	3	1	—	2	—	—	1	3	7
2	2	6	—	2	1	2	1	—	1	7
43	19	96	3	29	17	35	11	3	21	119
7	6	16	2	7	2	6	—	6	5	28
7	8	31	—	10	4	7	4	2	9	36
1	5	6	—	3	2	—	—	—	—	5
—	—	—	—	—	—	—	—	—	—	—

MORTALITY TRENDS IN CUMBERLAND

Year	Under 1	1—	5—	15—	25—	45—	65—	75+	Total
1927 ...	303	196	97	123	253	645	651	690	2958
	10.2%	6.6%	3.3%	4.2%	8.6%	21.8%	22.0%	23.3%	Rate 13.7
1937 ...	192	84	42	90	224	673	701	800	2806
									Rate 14.3
1957 ...	103	21	19	33	120	553	734	1057	2640
									Rate 12.1
1958 ...	108	18	9	24	113	607	677	1087	2643
									Rate 12.1
1959 ...	82	8	16	27	81	575	712	1110	2611
									Rate 11.9
1960 ...	91	13	19	21	105	554	677	1149	2629
									Rate 12.0
1961 ...	88	7	19	19	86	570	747	1189	2725
									Rate 12.3
1962 ...	108	15	13	15	114	574	759	1125	2723
									Rate 12.2
1963 ...	87	8	11	33	97	648	721	1208	2813
	3.1%	0.3%	0.4%	1.2%	3.5%	23.0%	25.6%	42.9%	Rate 12.5
1964 ...	76	19	14	24	88	626	705	1118	2670
	2.8%	0.7%	0.5%	0.9%	3.3%	23.5%	26.4%	41.9%	Rate 11.8
1965 ...	66	11	13	29	89	618	750	1130	2706
	2.4%	0.4%	0.5%	1.1%	3.3%	22.8%	27.7%	41.8%	Rate 12.0
1966 ...	77	6	13	25	96	588	732	1224	2761
	2.8%	0.2%	0.5%	0.9%	3.5%	21.3%	26.5%	44.3%	Rate 12.3
1967 ...	61	7	11	29	84	593	696	1071	2552
	2.4%	0.3%	0.4%	1.1%	3.3%	23.2%	27.3%	42.0%	Rate 11.3



MAIN CAUSES OF DEATH

BIRTHS AND DEATHS STATISTICS

Year		Estimated mid-year population	Births: Number	Births: Rate	Deaths: Number	Deaths: Rate	Excess of Births over Deaths
1917	...	223,713	4,671	20.8	3,013	15.0	1,658
1927	...	216,230	3,719	17.2	2,958	13.7	761
1937	...	196,080	3.131	16.0	2,806	14.3	325
1947	...	202,460	4,446	22.0	2,788	13.8	1,658
1951	...	214,700	3,681	17.1	2,827	13.2	854
1952	...	215,050	3,714	17.3	2,603	12.1	1,111
1953	...	216,100	3,608	16.7	2,571	11.9	1,037
1954	...	216,600	3,553	16.4	2,567	11.9	986
1955	...	216,700	3,556	16.4	2,653	12.2	903
1956	...	217,450	3,679	16.9	2,653	12.2	1,026
1957	...	217,600	3,901	17.9	2,640	12.1	1,261
1958	...	217,700	3,834	17.6	2,643	12.1	1,191
1959	...	218,900	3,888	17.8	2,611	11.9	1,277
1960	...	219,160	3,940	18.0	2,629	12.0	1,311
1961	...	221,460	3,900	17.6	2,725	12.3	1,175
1962	...	223.330	4.085	18.3	2,723	12.2	1.362
1963	...	224,630	3,964	17.7	2,813	12.5	1,151
1964	...	225,690	4,147	18.4	2,670	11.8	1,477
1965	...	225,570	3,916	17.4	2,706	12.0	1.210
1966	...	225,260	3,670	16.3	2,761	12.3	909
1967	...	225,100	3,601	16.0	2,552	11.3	1,049

LIVE BIRTH RATE 1953 TO 1967

CUMBERLAND AND ENGLAND AND WALES

PERINATAL DEATHS 1956-1967

Year	Stillbirths	Early Neo-Natal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal deaths per 1,000 births	
				Cumberland	England and Wales	Cumberland	England and Wales
1956 ...	111	64	175	29.3	22.9	46.2	36.7
1957 ...	102	64	166	25.5	22.5	41.5	36.2
1958 ...	80	69	149	20.4	21.5	38.1	35.0
1959 ...	83	54	137	20.9	20.8	34.5	34.1
1960 ...	111	60	171	27.4	19.8	42.2	32.8
1961 ...	76	53	129	19.1	19.0	32.4	32.0
1962 ...	78	71	149	18.7	18.1	35.8	30.8
1963 ...	76	60	136	18.8	17.2	33.7	29.3
1964 ...	77	47	124	18.2	16.3	29.4	28.2
1965 ...	80	37	117	20.0	15.7	29.3	26.9
1966 ...	60	40	100	16.1	15.4	26.8	26.3
1967 ...	70	38	108	19.1	14.8	29.4	25.4

CUMBERLAND COUNTY PERINATAL DEATHS

Analysis of Causes of 108 Perinatal Deaths during 1967

Cause of Death	Stillbirths		Deaths during	
	Premature	Full-term	1st Week	Total
Toxaemia	9	3	2	14
Ante/Partum Haemorrhage	3	—	—	3
Placental Insufficiency	2	3	—	5
Rh. with Antibodies	1	2	1	4
Maternal Diabetes	—	1	—	1
Prematurity	6	3	15	24
Congenital Malformations ... ... (incl. congenital heart disease)	9	4	5	18
Tentorial Tear	—	1	—	1
Asphyxia—				
Stricture of Cord	—	3	—	3
Cord Round Neck	1	2	1	4
Intra Uterine	1	2	1	4
Pneumonia Inhalation	—	—	—	—
Anoxia	—	—	1	1
Atelectasis	3	—	5	8
Cerebral Haemorrhage	1	—	3	4
Placenta Praevia	1	1	—	2
Macerated Foetus	1	2	—	3
Post Maturity	—	1	—	1
No Known Cause	1	1	1	3
Malpresentation	1	—	—	1
Pneumonia	—	—	1	1
Hypofibringogenaemia	1	—	—	1
Baby's Body Found on Shore ...	—	—	1	1
Form o/s	—	—	1	1
TOTAL ...	41	29	38	108

Infant Mortality

Cause of Death	Age in weeks Under 1	1 to 4	4 to 52	Total
oxaemia	2	—	—	2
rematurity	15	1	—	16
ongenital Malformations	4	1	1	6
sphyxia	3	—	4	7
telectosis	5	—	—	5
neumonia and Bronchitis	1	1	12	14
ongenital Heart Disease	1	—	1	2
erebral Haemorrhage	3	—	—	3
eritonitis	2	—	—	2
astro Enteritis	—	—	1	1
ther Causes	2	—	1	3
	38	3	20	61

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales for 1957 to 1967, are as follows:—

Year	Rates per 1,000 total live births Cumberland	England and Wales
1957 ...	26.4	23.1
1958 ...	28.2	22.5
1959 ...	21.1	22.2
1960 ...	23.1	21.8
1961 ...	22.6	21.4
1962 ...	26.4	21.7
1963 ...	22.0	21.1
1964 ...	18.3	19.9
1965 ...	16.9	19.0
1966 ...	21.6	19.0
1967 ...	16.9	18.3

NURSING SERVICES

Sections 23, 24 and 25 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to secure, whether by making arrangements with the Board of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period of not less than the lying-in-period, is adequate for the needs of the area.

It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own home."

DEVELOPMENT IN COMMUNITY NURSING

The concept of the family health care team pervades all sections of this annual report on Health and Welfare Services, and last year I wrote at some length on the development of the community nursing service. This year, 1967, has been one of considerable consolidation in some of these aspects of the work and of steady advance in others. This is clearly demonstrated in the individual sections which follow on Home Nursing, Health Visiting and Midwifery.

Considering the nursing service as a whole for a moment, I am happy to be able to report continuing success in these spheres where nurses come together outside their normal daily duties. The 'Return to Nursing' Clubs continue to flourish and to provide admirable recruits for a number of home nursing posts as these become vacant. Then a further successful residential course was conducted at Keswick in 1967 under the heading 'Home to Hospital' —more about this in the Home Nursing section of the report. I am led to wonder whether the highly successful post-graduate medical arrangements based on the District General Hospitals should not have a close counterpart for the nursing profession. Indeed I have already raised this question with hospital colleagues and the possibilities are at present under study.

On the question of administrative nursing responsibility in the teams based on group practice centres, the initial two appointments of Group Adviser have been a great success and I find this most encouraging. Perhaps the personal account of one of the group advisers, Miss James, of Seascale, given below is the most eloquent witness to the success of the pilot scheme. I cannot but feel that the concept of group adviser is more soundly based in the whole practice-based team than in say one special branch, e.g. Health Visiting.

Touching briefly on continuing research into the efficiency and effectiveness of community nursing, I have to report that a further detailed survey of the nurses' working day was at final planning stage at the end of 1967. I believe this kind of up-to-date fact finding exercise must be persisted in and well repays the time and effort devoted to it.

With these brief introductory comments I would like to quote quite fully from the reports of two senior members of group practices in the county, along with the comments of the Group Nursing Adviser in one of these practices, and the Southern Area Nursing Officer.

To Dr. T. Fletcher (Cockermouth) I am indebted for the following comments:—

"When Dr. Leiper first suggested many months ago the attachment of nurses to our practice I must confess that I was opposed to the idea. I felt at that time that it was wrong to abrogate the work of the doctor to the nurse.

"However, as I considered the idea while undertaking my daily work it soon became apparent that a good deal of time was wasted upon work which was well within the capacity of a nurse and that there was a great deal of work which the nurse could, in fact, deal with as efficiently as the doctor. My colleagues were of the same opinion and we therefore agreed to adopt Dr. Leiper's suggestion for a trial period.

"We have found the nurses a great help. While we are still experimenting to find the best way to use the nurse to the full advantage of doctors, nurses and patients alike, there is no doubt in our minds that to have a nurse attached to a practice can save the doctors a considerable amount of valuable time. This applies equally to the health visitor and Social Welfare Officer.

"When one considers the present growing shortage of doctors and the fact that present programmes require at least nine years to train a general practitioner it is obvious that such highly and expensively trained individuals should not have their time wasted on work that can be efficiently undertaken by someone else. In the hospital service much of the routine work is undertaken by the nurse under the supervision of the hospital doctor and there is a great deal of similar work which could be so delegated in general practice.

"We have found that the nurses can:—

1. Undertake many treatments in the patients' homes. For example when a doctor has prescribed a course of injections for treatment a nurse can take over the actual giving of the injections, reporting to the doctor on the condition of the patient.

2. Nurses can help in the supervision of cases of high blood pressure, diabetes, certain anaemias, of older persons living alone, etc.

3. Most immunisation procedures.

4. Deal with many minor injuries.

"To forecast just how much work the nurse might be able to undertake in the future is not easy but one feels that there is a place for the nurse in undertaking:—

1. Some of the re-visiting of patients in the less severe illnesses.

2. Some of the primary visiting with instructions to ask the doctor to visit the same day if she feels the case is more a doctor's case.

3. The diagnosis of the lesser infectious diseases such as chicken-pox, German measles, mumps, etc.

4. An even greater innovation would be for the nurses to visit such cases as 'Flu' and to be allowed to issue the necessary certificate but to report to the doctor any case which was not taking a normal course.

"It is necessary to recognise that this is a new conception of family doctoring and it will take time and goodwill on the part of all concerned to achieve the great benefits that can accrue by such a sharing of duties.

"If, however, the public are to have the full advantages of the great leap forward which has occurred in medical

knowledge in the last few years, and which is still accelerating then some method must be found to give the family doctor more time to devote to his more difficult cases. The use of nurses and of other ancillary staff to do the work which the doctor can reasonably delegate, would seem to be the natural answer.

"In brief, in spite of my original prejudice I have found the nurses attachment scheme of inestimable value and I would not now like to be without their valuable help. The patients benefit because we can give more time to our more difficult problems. Some patients have already requested a visit from the nurses instead of the doctor and so have clearly shown their approval of the scheme".

From the Southern Area, Miss J. Reid, Area Nursing Officer, puts a frame round the picture which has developed in Seascale. She writes:—

"In the Southern Area, the main development has been the formation in the Spring of the Family Health Care Team in Seascale. The group of four general practitioners, whose practice extends from Seascale to Bootle, has attached to it two nurses holding triple appointments, one home nurse, one part-time surgery nurse and two part-time relief nurses at the Seascale Surgery, and one part-time surgery/district nurse and her relief at the Bootle surgery. It was very soon obvious that a team of nurses this size should have a leader "on the spot" to deal with the day to day organising of the work, and on 1st July, 1967, Miss D. D. James was appointed Group Adviser. All the members of the team work part of the time in the surgery with the general practitioners, and they are finding the work very interesting indeed. They are learning far more about the patients' treatment, and their knowledge about the use of modern drugs has increased enormously.

"By the end of the year, eight months after the formation of the team, the work in this practice had increased to such an extent that the possibility of increasing the number of the nursing staff was being considered.

"I think that one of the major factors in the success of this Health Care Team has been the fact that they are working in a building that has been specially adapted for the purpose, and although it is now becoming a little cramped as their work extends, it has made a great difference to the success of the venture. Another factor has been the team spirit of the people concerned. Administratively, it has been comparatively trouble free, and Miss James has been a tower of strength.

"It is interesting to note that in this nursing team there are two nurses holding triple appointments, the Group Adviser being one of these, and in another small practice in the area the nurse attached is also similarly qualified. All three work extremely well with their practices, and it ameliorates the problem of the 'demarcation' line between what the health visitor does and what the general nurse does which still seems to puzzle many doctors. There are so many cases which clearly fall into neither one nor the other category".

And now, I am grateful to Dr. J. Loudon, Seascale, for the following:—

"Looking back over the past two years, it is interesting to recall what little use was made of Local Authority staff before the attachment scheme was instituted, and how casual were the contacts with that staff.

"Following the acceptance of nurse attachment, it was obvious that a great deal of effort would have to be made to reorganise our 'way of life', and it was decided that certain conditions would have to be fulfilled if attachment were to become a reality and not merely an administrative manoeuvre. Furthermore, it was felt that should nurse attachment prove successful then the attachment of other Local Authority staff might follow. The conditions are as follows:

"There should be daily personal contact between doctor and nurse for discussion of patients' care and progress, and each should know of the other's commitments for that day.

Face to face meetings would seem to be essential for proper understanding of patients' needs, treatment, and the reasons for such treatment.

"There should be confidence between doctor and nurse that each will be readily available to the other should the need arise.

"There should be an effort on the part of the doctor to make full use of the nurse's skills, and if possible to extend them by teaching, as so often in the past a nurse's skills have been allowed to atrophy through disuse, and once lost, such skills are not easily re-acquired.

"There should be total respect of patient's confidence—a patient should not feel that anything said to nurse or doctor is necessarily later relayed to the other.

"Patients should be encouraged to identify themselves with their nurse much as they do with their doctor.

"An attempt should be made to set aside some time each week for 'combined' visiting of patients whose day to day care is assigned to the nurse. Such visits can be of great value for doctor, nurse, and patient, and add to the nurse's authority.

"So far, the above conditions have been satisfied. Each day starts with a meeting to arrange the day's work, and ends with a further meeting to report on, and discuss, cases. No matter how inconvenient it may be, doctor and nurse are available to each other for any emergency which may arise, and in this context, the use of radio-telephone for communication is of great value. Nurse's skills are used to the full, not only for the usual nursing care, but for carrying out treatment, collection of specimens for the laboratory, and for 'follow-up' visits—she is given details of the progress expected in each case, and reports immediately if such progress is not made. One morning each week is set aside for 'combined' visiting of those patients whose day to day care is in nurse's hands. This

usually means visiting the old and the chronic sick, and is useful for carrying out examination of older people at periodic intervals. Nurse acts as surgery nurse during two evening surgeries each week, and as far as possible, all minor surgery, cervical smears etc., are done on those evenings. Nurse attachment has been an unqualified success, and has been extended to include a very 'loose' attachment of a Welfare Officer, who visits the surgery at a fixed time each week to discuss any welfare problem of the old, disabled, or needy. A great deal has been learned of the organisation and scope of the Welfare Services, and more effective use of them has been made.

"The experimental part-time attachment of the physiotherapist has been a great success, and has avoided many hospital referrals. Her services have been of great and lasting benefit to many patients after discharge from the hospital following treatment for strokes and other catastrophies.

"The one crying need to complete the picture is for attached home helps. In a country district with little or no public transport, mobile home help is essential, and it may be that a 'special' category of home help should be recruited for this purpose.

"The attachment scheme can thus be seen to help patient, nurse and doctor, probably in equal measure. There would seem to be no doubt that, adequately used and organised to meet varying local needs and circumstances, it could alleviate the shortage of doctors in general practice, and make the professional life of both nurse and doctor more satisfying".

Miss D. D. James is Nursing Group Adviser in the Seascale ractice and she writes as follows:—

"The attachment of nurses to general practitioners to form a team to cover all aspects of community care by consultation, communication and co-operation has meant many changes in our pattern of work. It has been done for three reasons:—

1. The benefit of the patient: This seems to be obvious. By daily consultation with the doctor to whom she is attached the nurse has full information about the patient-history, treatment and progress. Arrangements are made for doctor and nurse to be at the patient's house together, or an appointment can be made for the patient to see the doctor in the surgery at a time when the district nurse is acting as surgery nurse, thus providing continuity of care.

2. The benefit of the doctor: By relieving the doctor of some of the routine visiting, investigations and surgery treatments, it gives him more time for consultations and preventive medicine.

3. Benefit of nurse: By making full use of the nurse's skills, stimulating her interest and reasoning power and altogether increasing her job satisfaction.

"Our team has not yet been together for one year, and we have made many alterations and adjustments, all the time trying to make improvements. This has not been easy. The attachment of district nurses to general practitioners has meant a complete change in the lives of each, with give and take on both sides—sometimes involving considerable effort. Generally it has resulted in a much greater mileage for the nurse, and a longer working day, especially if she is an 'all purpose worker' and is involved in evening surgery work. This is compensated by the fact that she has the great satisfaction of being an integrated member of a team and is no longer working in isolation. I am convinced that this is the pattern of community care in the future".

Although Miss James mentions that attachment systems have resulted in much greater mileage being travelled by the nurse in her new duties, it must be remembered that over the county as a whole, the percentage increase in mileage travelled is similar to the percentage increase in the number of patients treated.

One of the most striking and interesting features of the omiciliary nursing service today is the role of the part-time arried nurse as a full or relief member of the Family Health are Team. I quote below from the comments of the area nursing fficers on this subject. I think they sum up the situation admirbly. Miss J. M. Till writes:—

"Basic requirements for a relief nurse on the district are (1) S.R.N. or S.E.N. training; (2) ability to drive and possession of current driving licence. The married nurse working in the community brings with her certain advantages and certain disadvantages. She has the ties and responsibilities of a family—possibly young children still at school, prone to all the infectious diseases associated with childhood. Unless there is a convenient and willing relative at hand the mother may have to cancel her work, often at very short notice to care for her child during the illness.

"Another disadvantage associated with children for the relief district nurse, are the long school holidays, and unless relatives or a suitable child minder can step into the breach the mother again has to forego work due to her home commitments.

"The younger married nurse also wishes to share her weekends with husband and family, and here we do come up against a slight difficulty as the regular full-time nurse should feel free to have at least one weekend off per month. This difficulty is largely overcome by cutting the work down to the absolute minimum over the weekend, enabling the relief nurse to complete her duties in a few hours each morning so that she can spend the afternoon and evening with her family. Most part-time nurses are willing to give up part of one weekend each month, but real difficulty does arise over the full-time nurses' holidays when sometimes extra help has to be called in.

"Most of these disadvantages are not encountered in the older married woman whose family has grown up, but if this person has been away from actual nursing for many years she has a very real feeling of inadequacy. This can, and is,

usually overcome by spending a few days working alongside another nurse. Should difficulties arise when working on her own the health care team really proves its worth, as she can discuss her worries during her regular meetings with the doctors, to whom she is attached, or with one of the other more senior members of her team.

"On the credit side the older nurse brings a maturity, depth of vision and wealth of compassion to her work which can be a very real help to her in meeting families in adversity and distress. She has a fund of experience of her own to call upon when advising her patients. This nurse often brings great enthusiasm to her work once she is established, finding fulfilment and interest in her work after many years of domesticity.

"The bulk of the district nurse's work is in the mornings and with good management it can usually be arranged that on days off the work can be completed before lunch time. This is ideal for the married nurse, leaving her afternoons comparatively free for her home commitments. It is not inconceivable that in the future all actual district nursing will be carried out by part-time staff".

From the Southern Area, Miss J. Reid, writes:—

"The employment of married nurses 'on the district' is not of course anything new—indeed for many years home nursing was one of the few posts open to the married nurse.

"With secondment, the increase in the numbers of relief and part-time staff has been drawn largely from the ranks of married women. I have found that after an initial adjustment period, even those nurses with a very young family organise their domestic lives to fit in with their new job.

"The forebodings that some of us had that the job of being a wife and mother would in cases of domestic crisis take precedence over any district responsibilities proved unfounded. In 1967 there were two instances where the mother's first day back at work coincided with an attack of measles in the family, and in another with the development of mumps, but

these were the exception, and in both cases things were quickly organised to enable mother to resume her duties".

The situation as it is operating in the Western Area is given by Miss J. M. Crossfield:—

"We employ fourteen part-time and relief nurses, all of whom are married. Six of these only work when the full-time staff are off duty. So far, this has worked very well and there have been only three instances when the relief was not available: once due to the nurse's child being ill, once when the nurse's husband died, and on the third occasion, the nurse herself was ill.

"On the other hand, when the reliefs have been asked to work at short notice due to illness of permanent staff, they have always done so.

"The routine arrangements for days off and holidays made on a monthly basis with holidays arranged when relief is available. The question of holidays has to take into account the leave arrangements of husbands and school holidays, as most of the full-time staff are also married and have children.

"One relief nurse arranges for her child to attend a play group when she is at work; the children of other nurses are all of school age.

"This is, I am sure, the ideal way to cover off duty of full-time staff as both doctors and patients know the relief nurse and the services can be maintained at a constant level.

"As the nurse and her relief work in apposition to each-other, the administration on a day to day basis does not involve a great deal of work.

"The greatest difficulty so far is to find sufficient relief nurses who are also motorists. At present there are two possible applicants having driving lessons, who could be employed.

"Of our total Western Area nursing staff, 21 full-time nurses are married, 15 are single and are mainly health visitors, and all the part-time and relief nursing staff are married".

Midwifery Service

The domiciliary midwifery service has continued in 1967 against a now familiar background of the continuing high hospital confinement rate and difficulty in maintaining adequate cover of the few domiciliary cases. It has, I believe, been shown that an adequate service can be maintained in such circumstances although it would be unsatisfactory to envisage a situation like this indefinitely. Ultimately it may be that only an acceptance of 100% hospital confinement will solve the problem. However, one has to deal realistically with the contemporary scene in midwifery while seeking an agreement with hospitals and general practitioners to mould the service to a satisfactory future.

While the overall situation of home/hospital evolves, one prominent question has been the future of the domiciliary midwife and the form that her training should take. Indeed, discussions in this area have largely been dominated by this subject in 1967 and important developments will undoubtedly occur in 1968. The overall background of the domiciliary midwifery service has, of course, been the development and maturing of the family health care team. This will be seen in this report as the foundation of all community health and welfare services, and none less so than domiciliary midwifery. The domiciliary midwife of the future must find a secure place in the team and I am fully confident that such a place awaits her. But first a word on the facts and figures of the service in 1967.

TABLE 1

Live and Still Births

Year	Total Births	Domiciliary	Institutional	Domiciliary Percentage
1955 ...	3,655	1,488	2,167	41
1956 ...	3,841	1,584	2,257	41
1957 ...	4,029	1,473	2,556	37
1958 ...	3,886	1,413	2,473	36
1959 ...	3,997	1,324	2,674	33
1960 ...	4,046	1,225	2,821	30
1961 ...	3,937	1,128	2,809	29
1962 ...	4,136	1,148	2,988	28
1963 ...	3,996	982	3,014	25
1964 ...	4,215	888	3,327	21
1965 ...	3,968	711	3,257	18
1966 ...	3,719	561	3,158	15
1967 ...	3,662	428	3,234	12

From Table I it will be seen that there were 428 domiciliary births in 1967—12% of all births in the County. The figure for 1966 was 15%. Thus the relentless trend continues and a breakdown of this situation into areas shows:

Northern Area	...	...	12%
Western Area	...	...	9%
Southern Area	...	...	14%

TABLE II

	1959	1960	1961	1962	1963	1964	1965	1966	1967
Domiciliary Midwives	76	74	66	73	74	69	49	40	36
Full-time Equivalent	46	44	39	44	43	22	19	14	13½
Institutional Midwives	42	42	44	53	55	60	59	50	53

Table II shows that the number of midwives employed in th domiciliary midwifery service has been reduced still further. O the 36 domiciliary midwives, 14 delivered less than 10 women i their own homes during the year.

These midwives paid 7,517 visits to patients confined at hom and in addition 3,225 visits to a total of 357 patients discharge from hospital before the tenth day. In addition, 4,186 ante-nata visits were paid to expectant mothers in their own homes and a ante-natal clinics attended by the domiciliary midwives and hel either in general practitioners' surgeries or in local authority clinic where a total of 760 expectant mothers attended. I am aware tha this represents a very low average number of visits paid in con nection with midwifery duties by the 36 domiciliary midwive employed during 1967. It should be remembered, however, tha of those 36 midwives only 4 were full time midwives, the remainde combining midwifery duties with home nursing or home nursin and health visiting.

Mothercraft and relaxation classes continued throughout th year giving valuable help and education to the expectant mothe A total of 403 mothers attended such classes conducted by th domiciliary midwives, a small increase of 44 over last year. Th total attendances were 2,697, an increase of 643 over the previou year. Even when it is remembered that similar classes are run fo mothers attending maternity hospital for their ante-natal care thi figure remains disappointing and I believe that doctors and mid wives concerned with the ante-natal care of expectant mothers hav a most important duty to keep before their patients the high im portance of such ante-natal education. There is a wealth of testi mony from mothers themselves to the value of such classes.

Five births took place in ambulances in 1967, three fewe than in the previous year. I hope that this might be due to bette informed mothers obtaining ambulance transport to hospital i better time than in the past, but the numbers are very small o which to base any conclusion.

Gas and air machines have been gradually replaced by th gas and oxygen Entonox machine and by the middle of 1968 th turnover will be completed and no midwife will be using the olde type machine.

Cases 'At Risk'

Against all of the above background of devoted work in the domiciliary midwifery service a major concern of mine has always been the number of high risk mothers booked for home confinement—cases which by longstanding consent of obstetricians, should unquestionably be confined in hospital. I am glad to report that in 1967 there has been a substantial reduction in the number of such cases confined at home—37 as against 64 in the previous year.

Of these 37 high risk cases booked for home confinement, 33 were actually delivered at home and 4 in hospital, 2 of which were transferred to hospital in the ante-natal period. The results of the confinements were:—

Stillbirths	Nil
Miscarriages	Nil
Live Births	36
First week death	1

Thus it will be seen that only one baby was lost of this group up to the end of the first week of life. Of the larger corresponding group the previous year, 4 babies were lost, 3 by stillbirth and one as a miscarriage.

Early in 1967 radio telephones were fitted in three midwives cars, in each of three administrative areas of the county. A full year's operation of this development has proved extremely encouraging. Doctors, midwives and patients in the areas concerned have found this method of communication effective and most reassuring.

Miss D. D. James of Seascale writes:

"The midwife is in constant contact with her "base" (i.e. ambulance station) while doing her rounds, and a patient has only to telephone the ambulance station to get a message relayed to the appropriate midwife. This eliminates much trouble for the patient, and saves both a great deal of time. If a midwife is already engaged with a patient and cannot leave her then the next nearest midwife is called in by radio.

"In my case it is a particularly useful means of communication, because the doctors in the group to which I am attached have similar radios installed in their own cars and there is also one in the surgery, so that we can all be in constant touch with each other if necessary. This saves much valuable travelling time in the large rural area in which I work. It also facilitates an urgent request for an ambulance".

Owing to the present financial situation plans to extend the installation of short-wave radios in nurses' cars has had to be limited to a further 4 in the financial year 1968/69. These radio telephones are linked to the ambulance network and the midwives have received every help and consideration from the control bases at the Ambulance Station.

The future domiciliary midwife.

It is clear that so long as a domiciliary midwifery service is to be made available to a community, less than 10% of whose mothers wish confinement at home, then the midwives engaged in such a service must be prepared to shift the emphasis of their work well away from the actual delivery of babies to the well planned and executed ante-natal and post-natal care of mothers, and I believe also, to the work of early paediatric nursing. This job must, in my view, ideally be carried out by a new type of midwife who is securely a member of the family health care team, whether she be a full time midwife or a person combining these duties with other nursing responsibilities. Should the day come when there are no births taking place outside of hospital at all, such a specially skilled person will in my view continue to be essential to an efficient midwifery service. Clearly a great deal of ante-natal and post-natal work will continue to be the responsibility of the general practitioner and this particular member of the nursing team will be central in this work. Although the actual confinement of mothers in their own homes has very understandably been one of the major attractions of domiciliary midwifery for many of the midwives who have chosen this field of work, I

believe that the absence of this part of the work to any great extent in the future, will be more acceptable to the new domiciliary midwife. I believe this because it seems clear that, as in all fields of domiciliary nursing (and, indeed, largely of hospital nursing too), the part to be played by the married nurse is increasing. These married nurses are often prepared for or even specifically seeking, part time employment. In these circumstances they are often more ready to fit in with a job which may seem incomplete in some respects to a career midwife. Nevertheless I do envisage this as a specialist nursing job and a very satisfying one at that. In a rural county like Cumberland there will no doubt always be many situations in which this newer concept of domiciliary midwifery will be combined with home nursing duties.

Training of midwives:

Training of pupil midwives is governed by Section B of the Rules of the Central Midwives Board in accordance with the Midwives Act, 1951. The course of training is divided into two periods, Part I and II, and comprises theoretical, practical and clinical instruction and the nursing of cases. Training is undertaken at hospitals approved as training institutions and all practical instruction is carried out under the supervision of a hospital tutor or a teaching domiciliary midwife.

The local health authority is concerned with the second period of training (Part II) during which the pupil midwife must spend not less than three months in domiciliary practice. During her period of domiciliary work, which is undertaken with a domiciliary midwife who has been approved by the Central Midwives Board as an approved teacher, the pupil must attend and take responsibility for a minimum of ten home confinement cases, together with attendance and nursing in the patient's home of a further ten cases during the lying-in period. The latter is defined as a period being not less than ten days, nor more than twenty-eight days, after the end of the labour during which the continued attendance of a midwife is requisite.

This has been the picture hitherto, as far as the part of the local authority is concerned in the training of midwives. I think at this stage I should include a commentary by Miss J. A. G. Hardie, teaching domiciliary midwife in West Cumberland on the situation as she finds it now with the drastic decrease which has taken place in the numbers of domiciliary confinements.

"During the year seven pupil midwives completed their three months' district midwifery training. I find working with them extremely stimulating and enjoy our discussions not only on the various aspects of midwifery but also about the social welfare side of our work—a subject on which the pupils show much interest.

"With the continuing decline in domiciliary confinements the pupils now work outside the Whitehaven area in an attempt to obtain the required number of cases. This creates problems especially with transport and they feel quite frustrated at times, either by having to hang about waiting for buses or by rushing visits in order to catch a bus.

"Although all of these pupils managed to deliver at least eight women in their own homes there was some anxiety if they had to wait several weeks for their first home delivery. Where two pupils are on district together there is less chance of cases being "lost".

"As the home bookings decrease, so unfortunately the ante-natal work decreases. All ante-natal work is now undertaken in the patient's own home; this allows pupil and patient to get to know each other well in a relaxed atmosphere. I think it is lack of sufficient ante-natal experience that eventually makes a midwife feel less efficient.

"On the whole there are not many early discharges from hospital, although this work can be both enjoyable and interesting. When patients are booked for an anticipated 48 hour discharge the pupils visit the home before admission to see the patient and make the necessary arrangements.

"During their training, pupils visit at least five child welfare sessions. Some think this is too many and that two or three sessions would be enough. They enjoy the visits and are always most appreciative of the help they receive from the health visitors. They also attend the relaxation classes.

"Although they still have occasional very busy spells, sometimes they are very quiet. This gives plenty of free time for study but I think most of them would rather be more fully occupied.

"Without exception they all do enjoy the home visiting, getting to know the whole family and seeing the relaxed attitudes of their patients. They are all impressed by the welcome they receive in the various homes they visit and by the help and courtesy shown them by the people in the street".

Ever since the fall away in domiciliary confinements became apparent in West Cumberland it was clear that sooner or later Part II Training as we know it would not be able to continue since the pupil midwives would not each have available ten home confinement cases. Discussions have ranged to and fro on this subject especially over the past two or three years and the Part II training scheme in West Cumberland has been in constant jeopardy. During 1967 a suggested alternative scheme was worked out by the Health Department and the West Cumberland Hospital representatives for submission to the appropriate authorities. Just at this point, however, advanced notice was given of a new scheme in combined midwifery training being sponsored by the Central Midwives Board. This was largely along similar lines to that which had been worked out locally and, at the time of writing this report, active steps are under way to secure a place for both East and West Cumberland among the pilot areas for the new scheme. The Newcastle region is one of the regions of the country to which this scheme is being offered.

This combined training scheme which replaces both Part I and Part II training of the past, involves a twelve week period of training in the domiciliary field for each pupil midwife working under an approved teaching midwife. During this time six de-

liveries should be undertaken in the home under the direct supervision of the teaching midwife, although three of these can be in a general practitioner obstetric unit. Fullest attention will be given to ante-natal and post-natal work and to neonatal paediatrics. It is envisaged that the teaching midwife will normally be a whole time employee of the Local Health Authority and she will be attached to a general practitioner obstetric unit. It may be necessary in some cases for a part-time teaching midwife to have a part in the scheme.

Emphasis will be placed on the family health care team approach based on a group practice centre and a very important part of midwives domiciliary training will be to give her a full grasp of a comprehensive community health and welfare service. As I have indicated it is possible that both East and West Cumberland will have similar schemes, the former being organised in conjunction with the City of Carlisle Health Department.

It will be immediately apparent that this new scheme of training will meet many of the difficult points associated with the present situation. In the first place it will cut to a very small number the domiciliary confinements required for the training period in a community: it will also give a fresh opportunity to reorientate the community based part of midwifery training so that midwives of the future will have a picture of a setting in which the domiciliary midwife will operate in the future. This encompasses all of what I have said above about the pattern for the future of domiciliary midwifery with minimal confinement responsibility and an extended and enlarged field of work in ante-natal and post-natal care and in early developmental paediatrics.

Local Maternity Liaision Committee:

In both East and West Cumberland three meetings were held during 1967 of the respective local maternity liaison committees. I am glad to say that these meetings are well attended and continue to bring together in a most useful way hospital, general practitioner and local authority professional people responsible for the maternity service.

A wide range of topics came under discussion, some of which have already been referred to in this report. Outstanding amongst these were the subject of Part II training of midwives particularly in West Cumberland: the consideration of peri-natal deaths due to congenital malformation; the methods of follow-up of defaulters from ante-natal clinics; the subject of communications in connection with early discharge cases and the obstetric booking survey being conducted nationally under the auspices of the Nuffield Provincial Hospitals Trust. This latter exercise occasioned both Hospital and domiciliary midwives a considerable amount of work in collecting data over a six month period concerning all mothers who were late in booking the services of either the hospital or domiciliary midwifery service. With regard to peri-natal deaths due to congenital malformations discussions lead to considerable correspondence with the Registrar General but unfortunately the amount of statistical help which might have gone some way towards elucidating some factors noticed in this area, was not available. In East Cumberland a prospective study of congenital malformation causing peri-natal deaths in being planned.

At a time when there is extensive National discussion an the future of the maternity services, I believe this kind of liaison at local level is essential and healthy. Both maternity liasion committees decided during the year that in the future, regular meetings would be held twice a year and it would be possible to call special meetings of the liaison committees at any time for special purposes.

Congenital Malformations.

Information on this subject is tabulated below.

The Ministry of Health's scheme for notification of all congenital malformations observed at birth has continued and in 1967 the number notified was 68, a slight increase over the figure for the previous year. In all, a total of 244 notifications have been received since the inception of the scheme in 1964. In 1967 the Local Health Authority introduced a revised birth notification card which provides for the notification of congenital malformations along with the actual notification of birth. This assists the notifying midwife in providing the required information in the appropriate cases.

The following table gives a breakdown of the total congenital malformations notified since 1964. It will be seen that 43 of the 47 stillbirths were associated with malformation of the central nervous system. The percentage of stillbirths, 19%, remains constant.

This information now collected nationally and annually allows constant analysis of congenital malformations notified.

	Males		Females		Total	
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Total cases notified	104	15	93	32	197	47
Central nervous system ...	16	14	24	29	40	43
Eye, ear	2	—	1	—	3	—
Alimentary system	13	—	12	2	25	2
Heart and great vessels ...	4	—	4	—	8	—
Respiratory system	1	—	1	—	2	—
Uro-genital system	16	—	1	—	17	—
Limbs	40	—	39	—	79	—
Other skeletal	4	—	1	—	5	—
Other systems	3	—	—	—	3	—
Mongolism	3	1	8	—	11	1
Other malformations ...	2	—	2	1	4	1

Prematurity.

A premature infant is a live born infant with a birth weight of 5 lbs. 8 ozs. or less.

The percentage of premature live births of total live births is 6% as in the previous year.

Premature births notified during 1967 are set out below with the 1966 figures for comparison.

1. Number of premature live births notified:—	1966	1967
(a) in hospital	218	222
(b) at home	22	10
(c) in private nursing homes	—	—
	240	232

2. Number of premature stillbirths notified:—		
(a) in hospital	34	51
(b) at home	3	3
(c) in private nursing homes	—	—
	37	54

There was a total of 7 premature babies born at home during 1967 compared with 10 during 1966; of these 6 survived.

Premature Live Births

Weight at Birth	Born in Hospital				Born at home or in a Nursing Home: Nursed entirely at home or in a nursing home				Born at home or in a Nursing Home: Transferred to Hospital on or before 28th day				Premature Stillbirth Born
		Died				Died				Died			
	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	In hospital	At home or in a Nursing Home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lbs. 3 ozs. or less ...	6	6	—	—	—	—	—	—	—	—	—	—	11	—
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	20	5	3	—	—	—	—	—	—	—	—	—	14	1
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	41	4	2	1	—	—	—	—	—	—	—	—	10	—
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	47	1	—	—	—	—	—	—	2	—	—	—	6	1
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	108	2	1	—	7	1	—	—	1	—	—	—	10	1
6. Total	222	18	6	1	7	1	—	—	3	—	—	—	51	3

HEALTH VISITING

The practice of health visiting has moved forward in Cumberland in 1967 within the essential context of the general practitioner led family health care team. Indeed, any meaningful practice of health visiting outside of this context is by now almost unthinkable in this area. All the essential elements in the professional work of a health visitor have been clearly demonstrated as finding their correct setting in the group practice with its integrated team of nursing and other professional members. This complete re-orientation of the work of the health visitor from the picture as it was some eight years ago in Cumberland is now being clearly demonstrated as logical and in alignment with the whole evolution of health and social services in this county. That family doctoring is to remain the foundation of the health services in this county has been amply re-affirmed in recent years and however medicine as a science develops, it is equally clear that the social aspects of medicine will always be of prominent importance in general practice. Now, the key non-medical worker in this field is a nurse with health visiting training and I have watched the rapidly extending appreciation of her value as such amongst family doctors in this county. With favourable adjustments in the conditions of practice, allowing doctors a little more time to study their medical work in the community in some depth, the sheer impossibility of the doctor dealing alone with the socio-medical aspects of his work become transparently clear. At other points in this report family doctors themselves give their testimony to the fact that, only now with an organised nursing team around them, are they glimpsing the pattern for the future of shared professional responsibility in the health of the community outside hospital. It is the permanent social element of the health visitor's training which places her in such a strong position here and this can safely, I am sure, be taken as re-assurance by health visitors as they consider possible future patterns of social work as a profession in this country. The Seebohm Committee report is still awaited and whatever organised form social work takes for the future the family doctor and nurse team will, without doubt, remain central in the promotion and maintenance of a healthy community.

Some of the long established responsibilities in health visiting will remain and flourish in a new light in the setting of the family health care team; amongst these are the health educative responsibility of a health visitor, her hand immensely strengthened by her close association with the doctor in the team. This applies to all forms of health education in the surgery or in the health centre and in the home. The gradual introduction of the family doctors to the child health services including the school health service again widens the health visitors' horizon in health education. The latter also begins to merge with another area of work namely health screening procedures. It is clear that amongst the elderly the maintenance of sound mental health is achieved above all by regular re-assurance about physical fitness. The part which health visitors in this county took in a recent pilot screening survey of a limited number of elderly people in their own homes (organised on a practice basis) demonstrates the kind of value which this work can hold for the future. At present plans are going ahead for the payment of a 75th birthday visit to all elderly people in the county. It is not that a trained health visitor must always personally undertake this work; I believe that much of it can be adequately and efficiently carried out by part-time nursing personnel who may not have had health visitor training. However, in the nursing team situation the guiding hand of the trained health visitor in organising such an exercise is of great importance. I cannot but think that all nursing personnel working in the community in the future must receive more and more basic training in social subjects even if all cannot attain the specialist level of the trained health visitor.

The current development in improved practice premises for groups of general practitioners plays an important part in the greater integration and efficiency of the whole team, though perhaps the advantages are less direct to the health visitor than to the home nurse who will have immensely improved facilities for surgery nursing. Nevertheless, a satisfactory 'base' for the whole community medical services is advantageous to the health visitor also. Allowing for the development of socio-medical consultation with more patients, the health visitor must realise however that her work is primarily in the home, and the home concerned will in-

creasingly often be that of an elderly person whose mental and physical health as mentioned above may well come increasingly to depend upon the services of a health visitor. Traditionally the health visitor has specialised in child health work but it is clear to me that the future may well hold more of a specialist paediatric nurse in community health probably linked to such domiciliary midwifery as will be practised in the future. If this comes about the health visitor may be called upon to relinquish some of her child health responsibility in the interest of the demanding and pioneering social and medical work being demanded by the elderly population.

In a rural county however I have no doubt that in certain situations the triply qualified community nurses continue to meet the need most adequately and indeed some aspects of the question remain open as to whether the future holds more for a community or public health nurse than specialised practical nursing and health visiting workers. No nurse who sees her career in the community, however, need be in any doubt that to take health visiting training will place her in a very strong professional position for the future. Four student health visitors joined the staff in the county on completion of their training during 1967 and are attached to practices in Maryport, Workington and Whitehaven. It is I confess a little disappointing to find that some of these ladies return, having received little or none of their field training in association with well organised and integrated general practitioner led team situations. I feel that it is essential that where it exists this weakness in health visitor training should be corrected as soon as possible.

Of a total of forty-six nurses practising health visiting in Cumberland (full-time equivalent of thirty-eight) sixteen are married ladies, twelve of these being full-time health visitors. Six of the forty-six hold triple appointments as home nurse/midwife/health visitor; two are health visitor/midwives and one is a health visitor/home nurse. I believe that this kind of pattern is to be expected to meet the varying needs of individual situations in a county of such varied geography and needs, as Cumberland. The essential role of the married worker is clear and although there are fewer

part-time married health visitors proportionately than there are part-time home nurses, I have no doubt that in health visiting also the proportion of married part-timers will continue to increase—a trend which gives me no anxiety but indeed considerable reassurance in terms of flexibility within the nursing teams.

The shift of emphasis which I have mentioned above in connection with the health visitors' work is well shown in the number of elderly visited during 1967. This was almost double that of the previous year, 4,630 compared with 2,422. The total number of visits to these elderly people increased from 11,105 to 14,519. The number of children under five visited decreased by almost 1,000 to 15,003. That this was really mainly an exercise in increased selectivity is shown, however, by the fact that those children received in total almost as many visits as were made in the previous year—53,058 compared with 53,073. It is only to be expected that the element of selectivity should be strengthened by the integrated team approach to health in the community.

The children and the elderly account for about 90% of the visits which health visitors make. The remainder are to be mentally disordered, persons discharged from hospital, the tuberculous, households with other infectious diseases, and in connection with cervical cytology, the Home Help Service, Meals-on-Wheels, etc.. In aggregate 72,540 visits were made, which was a 9% increase on the 66,705 made in 1966.

I think the following brief comment by Miss J. A. G. Hardie, a health visitor/home nurse/midwife is very significant. Miss Hardie has worked for many years in a rural area and is now securely attached to the two general practitioners working in that area. She writes:—

> "The biggest change of all is with health visiting. All visits are now undertaken for a reason rather than because they are due. My help in organising the social welfare needs of the elderly and handicapped patients appear to be of some value to the doctors. I conduct child welfare clinics on my own referring children to doctor if necessary".

And a comment from a full-time health visitor in another team. She comments on one of the earliest practice-based approaches to preventive health and health education in the problem of obesity. Mrs. Lythgoe writes:—

"A more complete service for the patient appears to be one of the biggest advantages in having the family health care team within general practice.

"Delay in dealing with patients' problems can be reduced if one can meet the patient on the initial visit to the surgery as often happens within our practice.

"The advantages of teamwork is appreciated by the general practitioners. Our senior member considers that home visits are cut down as a result. Much depends upon the recognition of minor problem cases who could become the very ill patient of the future.

"With this in mind we commenced a Weight Reduction Clinic for all ages. Patients are weighed weekly. Advice on diet and on food values is given, taking into consideration the varying eating habits within families and giving each case individual thought."

The return to nursing clubs are mentioned elsewhere in this report and it is refreshing to read the thoughts of one member who progressed through the club to take up work in schools which at one time was almost exclusively carried out by health visitors. The latter having already initiated colleagues into work in the schools will continue to support and advise such nurses in this important field. The member of the club concerned writes as follows:

"I joined the "Return to Nursing Club" without much hope that it would provide more than an evening out a month and some professional contacts. I wanted to work, and had previously applied for a part-time hospital nursing post but with no success—I felt defeated and humiliated; no one wanted to employ a part-timer with five children and a gap

of evelen years to catch up. Still, I'd try anything once, I thought, and went along. The first evening I met two people from the district where I live, and we agreed to come regularly together—which is probably why we all kept on coming! The talks and discussions on present day community health care and nursing were interesting and stimulating, and gave me plenty to think about during the following days—a change from "What shall we eat for breakfast, lunch, tea, supper!"

"After a few months, those of us who were able to work immediately attended a "Refresher Course" on six successive Fridays, at the very civilised time of 10 a.m. to 4 p.m. This was great! Everyone was very kind, and no one treated us as second-class citizens. The lectures and visits to old people's homes, training centres, and ambulance stations etc. were excellent, but I thought the nicest part of all was spending the day in College, having lunch in the canteen, and talking to like-minded people in circumstances similar to my own.

"At the end of the course, I felt much more confident of my ability to take up my career again, and I was very pleased when, some weeks later, I was offered a post as school nurse in my own area. The work is interesting, but not difficult and the fact that the work is done during school hours suits me. I meet the other full and part-time nurses attached to the group practice in the area, and am getting to know the teachers and children at the schools on my "round".

"I feel that I have had a very easy re-introduction to work outside the home, but I am sure that the ease and success of this venture is due, in a very large measure, to the "Return to Nursing Club" and those who run it."

I believe that the field of professional work for the health visitor promises to be more rewarding than ever before in the modern context of integrated community health services. I have outlined some aspects of this above but it should also be remembered that integration should also proceed apace with the hospital service. The health visitor was one of the first community health workers ever to penetrate hospitals in liaison with their child

health and maternity services. Should the medical officer of health or non clinical community physician of the future find himself with a base in hospital—or in fact if his principal base continues to be in the community but with secure links with the hospital service—then I see the health visitor in a central role in the community service as one of the non clinical community physician's principal lines of communication through a more unified health service. Not before in my view has nursing in the community including the special skills of the trained health visitor had promise of such a rewarding and satisfying career.

HOME NURSING

Thinking now of the home nurse in the context of the family health care team—she is a highly trained member of the community, and to give of her best to the community she must get some real job satisfaction herself. Is she too highly trained to do the job she is doing at present? Is she really using all her skills both practically and intellectually? Much of the work she is doing could be done by much less highly qualified people. More and more State Enrolled Nurses are being trained: what a valuable contribution they could make to the domiciliary family health care team. Bath attendants could be employed in larger numbers to allow the fully trained home nurse to be available for skilled nursing procedures.

There seems to be a general pattern of staff personnel evolving a group of nurses, all with different skills and abilities working together for the good of the community, and the care of the individual patient with relief nurses attached to each practice to make sure that there is a maintained standard of patient care.

During 1967 theory has gradually become practice and perhaps a good guide to its success is what a nurse really feels and thinks about the changes herself.

Mrs. L. Messenger, who has been on the staff at Workington for over ten years writes:—

> "I think the major change of the decade has been the attachment of the home nurse to the general practitioner. This attachment has been and is of great benefit to the family doctor, the home nurse and, most important of all, the patient. I feel much more a part of a team now that I ever did before secondment; a great deal more information about the patient is available to me; I am made aware of his past history, his visits to the hospital, his X-ray and pathological reports; in short, I know my patient better than ever before. Consequently, I am able to be more interested in the patient than hitherto. I can find out the results of my treatment and whether or not it has been successful.

"In pre-secondment days I have perhaps attended a particular patient six times a week for several months to give him injections of streptomycin (I used to presume these were given for a tuberculosis infection, but more often than not was never told until I asked). The patient would then be called to see the consultant, who would decide no further injections were needed and that, more or less, was that! I am in the picture now, I can follow the patient's progress by reading the hospital reports, X-ray reports etc. Finally, when the patient is taken off his treatment I can find out without going to a great deal of trouble whether the treatment has been successful or not.

"I feel also that my patients have much more confidence in me, as they are very much aware that I am their doctor's nurse and that I work very closely with him.

"A good relationship is necessary between the family doctor and the attached nurse, otherwise I would say that the attachment would be fruitless. I like to think a good relationship exists between my doctors and myself, but in spite of this, I still feel the doctors could make better use of me and the services I can offer them. I recently commenced a cervical cytology clinic with one doctor and I feel that this is a very worthwhile step forward. In one afternoon session at the surgery four out of the five patients seen had cervical erosions and had to be referred for treatment.

"I am often asked to accompany the doctor on domiciliary visits for the purpose of doing vaginal examinations etc. This service is appreciated by the patients, especially for the mothers of young children who find it difficult to attend surgery. I also feel it saves the doctor time as I arrive at the house before the appointed time and have the patient ready for examination before the doctor arrives.

"The introduction of relief nurses (part-time) is another change which ensures continuity of care and I feel much happier when I go off duty knowing that a particular nurse is looking after my patients.

"I find much of my time is used up supervising and advising both patients and relatives. I feel that all elderly people, especially those who live alone, should be visited by a qualified person at least once a month.

"I am very happy to be attached to the family doctor and would not like to return to pre-secondment days".

Here are the views of Mrs. F. Corkill, a district nurse, on the problems of staff attachment in a very rural area:—

"The result of the attachment of home nurses to general practitioners has been a much closer liaison between the doctors and nurses which is definitely satisfying. The feeling of being a recognised member of a team is inspiring.

"Some disadvantages have to be overcome in rural areas. In a very remote area such as Ennerdale Rural District, I know some patients and their relatives who have felt concern that they are unable to have the services of the nurse living nearest to them. These people are still apprehensive that their nurse or midwife may now live several miles away and is no longer within easy reach. At times the distance separating nurse and patient can give rise to anxiety in case any emergency should occur".

Home nurses working in the general practitioners' surgeries have proved a great success, the work being both interesting and varied. During 1966 there were 2,517 treatments in general practitioners' surgeries, while in 1967 there were 8,007 treatments given, an increase of 5,490.

Miss A. Keenan, surgery nurse, Whitehaven, gives her views of the advantages of this type of work:—

"The advantage to the general practitioners is that it saves them valuable time—cutting their surgery time by approximately a third—when they can send the patient to the nurse to have all tests and treatments done.

"For the patients it saves time too. When routine treatments have to be carried out patients come straight to the nurse and occasionally can carry on with their work with the minimum of time lost. School children can go on to school after having their treatment without missing valuable schooling. Sometimes, because of shyness, patients are more willing to confide in the nurse about their more intimate symptoms."

Miss J. A .G. Hardie, district nurse/midwife/health visitor, from Distington, has the following observations to make:—

"After working as a district nurse/midwife/health visitor on a rural area for 13 years I have been attached to a general practice for almost one year. On the general nursing side more knowledge of patient and treatment is available. One feels useful in helping with investigations and follow-up work and the intermediate visits I am asked to do give more variety to my work as well as saving doctors' time for more important visits. I see many more patients of all age groups and as a result of some of these visits I have to spend more time reading and revising than I did in the past.

"More recently I have started working in the treatment room during the morning surgery. Dressings, injections, antenatal and post-natal examinations, cervical smears etc. are carried out here. At present the work fluctuates a great deal but I think it will build up.

"After surgery comes the report and planning of the day's work; occasionally we plan domiciliary visits together. Plans for the future include minor surgery in the treatment room and more follow-up visits to patients suffering from certain diseases e.g. hypertension, pernicious anaemia etc.

"The volume of work and travelling has increased enormously. I now have to make a very early start in order to give general nursing attention (especially to patients who are incontinent) before going to a surgery at 8.45 a.m. However, satisfaction from the work has also increased—I no longer have time to feel bored".

What now is the way ahead? We must plan and think of the future. The future must see a closer working relationship with the hospitals. More thought must be given to patients awaiting admission to hospital, the duration of stay, and planning before a patient is discharged.

With this in mind, a successful week's in-service course was arranged at Underscar, Keswick, from 1st-6th October, the theme of which was 'Continuing Patient Care'. Eleven members of nursing staff attended from hospitals together with 28 home nurses, 19 of whom came from other local authorities. There was free interchange of ideas from the hospital and home point of view of caring for patients and the discussion groups were thought —provoking and enjoyed by all. The lectures were forward thinking and really interested in the terms of total patient care in the community.

If nothing else was learned from this course I am sure that no member could any longer feel that the hospital was not part of the greater community service and that it is essential for hospitals, general practitioners and local authorities to work together in the interest of the community.

By the end of 1966, 80% of the home nurses and 85% of the home nurse/midwives had been attached to the general practitioners. This programme was completed in the earlier part of 1967 and the next phase of the building of the family health care team was embarked upon. This is the provision of part-time nurses and/or auxiliary nurses for each of the home nurses so that each group practice and its associated nursing team will be eventually self-contained.

By the end of 1967, 36 home nurses were employed in a part-time relief capacity giving invaluable support to the full time members of staff.

We are fortunate in Cumberland in having an ample source of nurses, most of whom are members of the 'Return to Nursing' Clubs, to draw upon for this part-time work.

From the following table it can be seen that over the year here has been an increase of over 10,000 in the total number of nursing visits.

As the total number of patients nursed was only increased by .7% over that for 1966, it is obvious that more visits were paid per patient.

The number of children under five years who were visited shows an increase of 85 on the 1966 figure but the 1966 figure was abnormally low. Nevertheless, looking back over the past five years the trend towards a decrease in the number of visits to children under five is apparent.

This decline is counterbalanced by the increase in the number of visits paid to the elderly which have been steadily increasing from 48% of the total number of cases visited five years ago to 56% in 1967. More time is also being spent on malignant diseases and while the numbers are not large there has been an increase of almost 25% over the past five years.

Home Nursing

	Total number of persons nursed during the year	Aged under five at first visit	% of total cases nursed	Aged 65 or over at first visit	% of total cases nursed	Remaining cases	% of total cases nursed	Surgery treatments	Total number Nursing Visits
1963	6083	455	7%	2933	48%	2447	41%	—	125,266
1964	6167	448	7%	2966	48%	2468	41%	—	134,305
1965	6105	433	7%	3059	50%	2334	38%	—	150,656
1966	6159	276	4%	3479	57%	2120	34%	2517	161,984
1967	6331	361	5%	3516	56%	2454	38%	8007	172,415

HOME HELP SERVICE

Section 29 of the National Health Service Act, 1946

"A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother ....., aged, or a child not over compulsory school age, within the meaning of the Education Act, 1944".

HOME HELP SERVICE

There have been no new developments in the Home Help Service during the course of 1967, although at one stage of the year there was some concern that the service was expanding at a quicker rate than the financial situation would permit. However, this situation eased and the year as a whole showed only a small increase in the number of households assisted during the previous year, from 1301 to 1324. This is a smaller annual increase than usual. Many of the cases were of a long term nature but on looking at the small increase it must be borne in mind that in view of the economic situation there was a review of the hours devoted to individual cases and overall a 5% reduction in time was achieved.

The following table shows how these cases were spread over the three administrative areas.

Area	No. of Home Helps	No. of Households assisted
Northern	113	390
Western	60	458
Southern	77	476
	250	1324

The very different ratio of home helps to households in the Western and Northern areas warrants some explanation; it is simply that in the Western area with its greater density of population and better transport facilities home helps can each easily deal with several households, whereas in very rural Northern area it is commonplace that a home help can only serve one household.

As a result of the decrease in the number of domiciliary confinements the Home Help Service is devoting a decreasing amount of its time to maternity cases. This is, however, more than counter-balanced by the increasing amount of work arising from the growing number of elderly in the community. During 1967 just over 80% of the cases visited fell into the category of elderly and only 2.5% were maternity cases. The remaining 17% falls into the general classification of miscellaneous, by far the biggest group within this being the chronic sick and tuberculous.

The home help vans which are available in the Northern and Western areas of the county are proving invaluable in providing a service for those who otherwise may not have been able to get it because of transport difficulties.

In the course of the year the drivers of these vans helped 45 households. The provision of a van to serve the Southern area is eagerly awaited as there are several households which are proving difficult to assist.

In 1966 in response to the Ministry Circular 26/65, the local authority had reviewed the Home Help Service and had decided among other things to continue to make a minimum charge of 5s. 0d. per week. Towards the end of 1967 the Ministry asked the local authority to reconsider this decision and after further consideration it was again decided to adhere to the minimum charge. It was felt that no great hardship was being caused by this change as the authority had already authorised the County Medical Officer with the County Treasurer to waive all charges where it was felt necessary. It was also in mind that although this authority does charge for the Home Help service, it provides a free chiropody service and loans nursing and other equipment free of charge; as all these services tend to apply to the same group it was felt that nothing would be gained by taking the charge off one and possibly having to introduce it on the other services on purely financial grounds.

There can be no doubt in anyone's mind as to the necessity and value of the Home Help Service, as the following reports suggest:—

A lady of 80 years of age, who is crippled with severe arthritis and has been receiving the services of a home help since 1959 says:-

"I now manage fairly well with the kindly helps you have arranged—one for preparing a simple breakfast and getting a fire going in the living room. At midday the home help comes by car and prepares a simple meal as quickly as possible. I am alone for several hours and jog about slowly and painfully when necessary to attend to necessary little jobs. A thermos flask of

tea is prepared as I am unable to use a kettle of boiling water safely and hold on to my walking aid. I am exceedingly grateful for the assistance my two kind home helps give me in the short time they are with me."

The Home Help Service has undoubtedly changed over the years but one tends to overlook the radical changes in the community and their effect on the service as Mrs. D. Armstrong, a Home Help, makes so clear in her report:—

"As a home help for quite some time I look back and note the great improvement in the standard of living. Gone are the days when the first job of a home help was to carry water, fill the oil lamps, etc., clean and blacklead huge fireplaces. Yes, indeed, household chores are much easier now, but people don't seem to change a great deal. It can still be hard work winning the confidence of the elderly—some react much quicker than others but until this is achieved days can prove very exacting.

"It seems to me that the households we attend can be put into two classes. First are the types who appreciate what we are doing, these usually are the most needy, the bedridden, the very lonely, the ones who have lost their partner and are alone and miserable. In these cases the home help is more than someone who comes in to cook and clean. She is a friend, a ready listener, someone who understands. The second class are the difficult, never satisfied type who have a grudge against all and sundry, and though I am sure every home help at one time or another when faced with this problem has thought of giving up the work, then thinks again and carries on, feels a very great achievement when one day this person says "I don't know what I would do without you".

"I have one such difficult case at present, I am told daily of the stupidity, lack of manners, ignorance of everybody, from the postman, all tradesmen, even the family doctor, so I don't expect anything I do to be right. After all I am just the home help who has been trying for two years, but who knows ?

"My second household of the day belongs to the first category where all I do seems to be appreciated so it is not all a losing battle.

"Whoever said "A home help must have patience, understanding and a sense of humour" certainly knew what they were talking about."

The home helps play perhaps an ever more important role by their encouragement and inspiration to the people with whom they meet from day to day.

Mrs. M. Trohear, from Maryport, comments:—

"I find that households do improve when there is a home help. For example, you may be sent to a home where the wife has been ill for a time and things have got down a bit, but when she sees the home help doing her work and things beginning to look nice again—even though she's still ill—she starts to take a pride in her home again."

The Family Help Service.

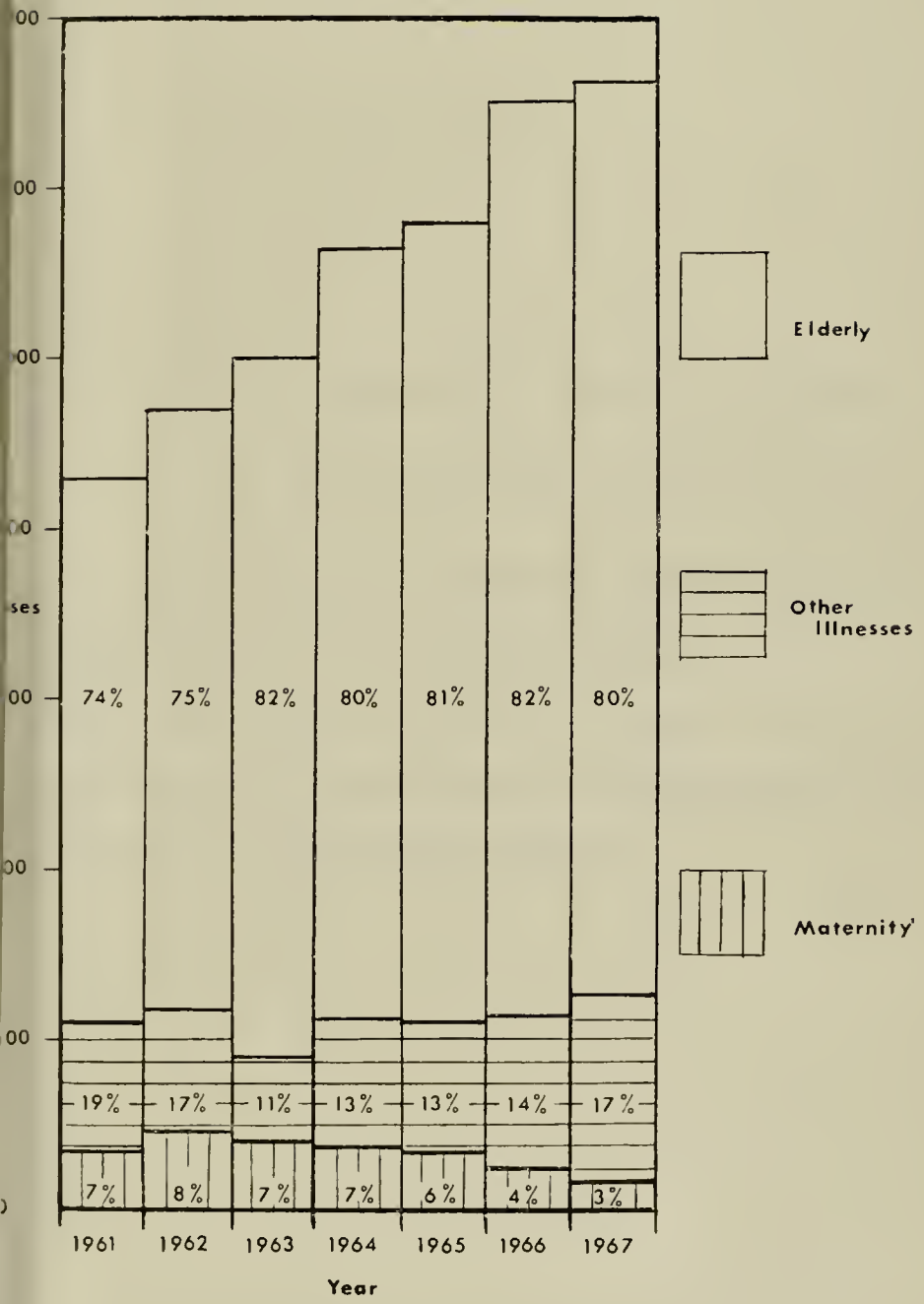
One home help has for nine months been trying to support and help a mother and her six children whose husband is working away from home. The house itself was too small for the needs of the size of family and the mother inadequate to overcome such hardships and problems on her own.

The home help, Miss E. Byers of Wigton, reports:—

"I suggested that she baked a few things for the children and I am glad to say she does this occasionally and she also is beginning to cook the children a hot meal. I tried to comfort her when she lost her baby under very tragic circumstances and when her husband asked her to divorce him. Conditions have improved in the home and she seems to be more interested in keeping house although even with the help I try to give her she still has a long way to go."

How much preventive medicine and teaching of positive health is achieved by the home helps is difficult to ascertain but one can imagine that it must be quite considerable.

HOME HELP CASES



CARE OF MOTHERS AND YOUNG CHILDREN

Section 22 of The National Health Service Act, 1946

"It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority".

CARE OF MOTHERS AND YOUNG CHILDREN

This section of my annual report brings together an account of several services which have a particular bearing on this specially important section of the community. These services include child welfare centres, the dental service for this group, the work of the marriage guidance councils, family planning services, and the care of the unmarried mother and her child. I have taken certain statistical comments over this year into a single short section beginning on page 26.

The increasing fusion of all community health services leaves this group 'Mothers and Young Children' less prominent as a special Local Authority responsibility than in the past. It takes its place alongside the elderly, the mentally disordered and the handicapped in sharing the time and attention of the whole team of workers led by the family doctor. Many of the mortality and morbidity problems of the group have seen great amelioration over the years and its care is now passing to newly orientated and specially trained workers. I refer, for example, to the future domiciliary midwife/paediatric nurse envisaged elsewhere in this report, and to the past which the family doctor, with appropriate re-training, will play in the emerging child health service as foreshadowed in the Sheldon Report on Child Welfare Centres.

Care of the Unmarried Mother and her Child

The provisions of the National Health Service Act, 1946, place no specific duties upon local health authorities for the care of the unmarried mother and her child as distinct from their statutory responsibility to make arrangements for the care of expectant and nursing mothers and of children who have not attained the age of five years.

The provision of mother and baby homes many of which are supported by local health authorities and since 1918, by the National Council for the Unmarried Mother and her Child, have in the main been established by voluntary organisations which though smaller than the statutory bodies with whom the unmarried mother and in particular her child come into contact in later life play an important role in community care.

It is of interest that out of a total of 149 establishments caring for the unmarried mother in England, Ireland and Wales, 114 are mother and baby homes and 35 combined maternity homes. Of the former, 21 are under the control of the appropriate local health authority and only one of the latter. Thirty-four combined maternity homes are run by private bodies who are dependent upon grants from local health authorities and other voluntary sources.

The vast majority of unmarried mothers are confined in the Maternity Unit of the District General Hospital but sight must not be lost of the service given to the community by the voluntary organisations and their case workers in supplementing or complementing statutory provisions. Such service particularly that of the Moral Welfare Associations whose social workers are primarily concerned with people who need help with problems associated with unmarried parenthood and with children in 'moral danger' is by the financial support which is readily given by local health authorities in the maintenance of the unmarried mother during her stay in mother and baby homes.

It seems clear that the greater need, in terms of limited financial resources, lies in the advancement of the skills of the social worker amongst this group, rather than in the provision of

eparate and special maternity homes with all the expense and aff problems they involve.

During the year the number of illegitimate children born to umberland mothers was 236. The number of cases for which nancial assistance was requested was 24 the lowest figure for n years which is indicative of the trend to hospital confinement. he age groups of the 24 unmarried mothers for whom the County ouncil accepted financial responsibility during 1967, can be een from the following table, the significant age group being 19-24 ears.

Age	1967	1966	1965	1964	1963	1962
3 years	—	—	—	—	1	—
4 years	—	—	—	—	1	2
5 years	1	—	1	4	3	3
6 years	2	3	6	3	—	5
7 years	2	10	6	4	2	4
8 years	4	5	13	5	3	7
19—24 years ...	13	18	31	21	12	12
25—30 years ...	1	4	2	1	7	4
31 years and over ...	1	2	1	3	2	1
TOTAL ...	24	42	60	41	31	38

The average number of patient days resident after confinement together with the actual number of admissions to each home is indicated below.

	Admissions	Average No. of patient days resident after confinement
Coledale Hall, Carlisle ...	10	30
St. Monica, Kendal ...	7	48
Brettargh Holt, Kendal ...	2	45
Other Homes	5	26
	24	

It is widely accepted medically that the young unmarried mother should be regarded as a high risk case for confinement and should be admitted to hospital. A number of those admitted to St. Monica Maternity Home have subsequently been transferred to the local hospital but some have been confined in the Home itself. This authority felt that in view of the limited facilities available and the possible loss of professional skill amongst the midwives because of the small number of deliveries undertaken, the confinement of mothers at St. Monica Home should cease as soon as the local maternity hospital confirmed that all the mothers could be confined there. It was felt that at the Home itself it would be better to concentrate on the social and moral welfare problems of the mothers rather than on midwifery. The participating authorities were therefore recommended by Cumberland to ask the management committee to have the status of the Home changed to a Mother and Baby Home. The participating authorities were equally divided for and against the recommendation, while the management committee wished to retain their maternity home status. Negotiations are continuing.

Distribution of Welfare Foods

Welfare foods are available under the Welfare Food Orders, 1954, (S.I., 1954, No. 1401, and S.I., 1954, No. 1402) as subsequently amended, and except for liquid milk are distributed on behalf of the Ministry of Health by local health authorities as part of their duties under the National Health Service Act. Liquid milk and national dried milk are provided at a subsidised price and other foods at the cost price, to expectant and nursing mothers, children under five years and certain handicapped children. In cases of financial hardship all the foods are supplied free of charge.

The arrangements for the distribution of welfare foods for which the Area Medical Officers are responsible, from County Council Clinics, private traders and through the good offices of the Women's Royal Voluntary Service continued during the year.

There was no change in the number of distribution points of which there are approximately 100 situated within the administrative county nor in the transport arrangements for the conveyance of foods to isolated areas, a service which is undertaken by the Women's Royal Voluntary Service who actually act as agents on behalf of the Cumberland County Council.

The following table shows the extent of the distribution of welfare foods during the last ten years.

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin Tablets (Packets)	Orange Juice (Bottles)
1958	115,685	15,198	6,338	89,366
1959	105,984	15,350	7,076	93,684
1960	92,676	14,961	7,475	90,343
1961	78,155	9,067	5,017	50,653
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,943
1964	74,886	4,909	2,236	36,389
1965	78,047	4,636	1,881	39,053
1966	74,902	4,326	1,771	41,636
1967	69,460	4,131	1,405	43,459

The continued drop in the sales of national dried milk, cod liver oil and vitamin tablets coupled with the increasing sales of organge juice would appear to be a national trend. A decreasing birth rate undoubtedly is responsible for the declining sales of the commodities which the expectant mother has been educated to obtain for herself and children.

DENTAL SERVICE

The Chief Dental Officer, Mr. R. B. Neal, M.B.E., T.D., L.D.S.R.C.S., makes the following comments on the dental service for 1967:—

This report covers only the dental service provided for infants under school age and expectant and nursing mothers. Over 90% of the service's work is in connection with school children and a separate report on that aspect appears in the annual report on the school health service.

Over the year there has been a decline in the attendances of maternity patients. This is in no way a reflection on the local authority's service but is due to the fact that more patients are electing to receive treatment from their own general dental practitioners. Such a declining requirement does not cause concern so long as the prospective patients are in fact being treated elsewhere, but one cannot help thinking that there must be some who are electing to go elsewhere but are not doing so. This applies also, of course, to some of the children. When they are finally seen for emergency treatment it is patently obvious that they have not been under treatment by anyone.

Towards the end of the year approval was given to a proposed scholarship scheme for dental auxiliaries, under which a special grant of £100 a year would be given to any Cumberland student who was accepted for training as a dental auxiliary by the Dental Council and who agreed to return to Cumberland to work for a period of not less than two years after completion of training. The headmasters and headmistresses of all secondary schools in the county were asked to bring the scholarship to the notice of suitable pupils and I offered to speak to interested groups. In this way it is hoped to overcome some of the staffing difficulties, although it is a long term solution and I cannot be optimistic about any immediate improvement on the present situation—probably the most acute staffing situation the county has known in dentistry—where four of the eleven posts on the establishment are unfilled.

Despite the shortage of staff, no maternity or child welfare patient had to wait for an appointment and all requests for treatment were dealt with. The need to use dental auxiliaries will mean a re-appraisal of the dental service as auxiliaries can only be used in surgeries adjoining those used at the time by qualified dental practitioners. As a result, few single surgery dental suites are likely to be provided in the future and it may well be that the use of some of those now in existence will cease. The cost of providing dental suites and the difficulty in staffing them is likely to be such that there could be fewer clinics as we recognise them today and only at places where they can be fully utilised. Where the dental suites are provided in health centres it is hoped that the financial problems which now exist can be overcome so that the suites can be used also by general dental practitioners.

Apart from the provision of new surgery suites the perennial problem of bringing up to date those of the existing suites will be retained. The plan formulated and approved by the County Council a few years ago for the re-equipment of dental clinics should have been completely implemented by now, but because of a succession of financial crises and consequential cutting of estimates, only half that programme has in fact been carried out.

Operating the service with a seriously depleted staff imposes sufficient problems and it is therefore hoped that the situation can be eased as much as possible by a speed-up in the improvement of operating facilities and the waiting accommodation which, at some clinics, is much below standard. The adverse effect these have on patients and parents is often hard to overcome, even by the best and most understanding of dental officers.

Fuoridation of Water Supplies

It is now four years since the County Council approved in principle the fluoridation of public water supplies in the county where they are deficient in fluoride naturally. This positive exercise in preventive health was not expected to be carried through immediately as there had to be many discussions, then possibly the phasing of fluoridation with other work. There have been discussions with all the water undertakers in the county and three out of six have agreed to adjust the fluoridation level in their supplies.

The only firm plans for fluoridation are in the West Cumberland Water Board's area where the necessary equipment is being installed in new treatment works under construction at Crummock Water and expected to be in operation in 1968. That water supply serves a population of about 60,000 in the Workington/Maryport/Cockermouth areas. It has also been agreed in principle that the Board's supplies drawn from the Quarry Hill and Hause Gill sources will have their fluoride content adjusted as opportunity permits, the intention being to co-ordinate the installation of equipment with improvement work to be carried out by the Board. Firm dates for this work have not yet been settled.

Negotiations with the Keswick water undertakers were not so successful but it is understood that responsibility for this undertaking will pass to the West Cumberland Water Board and it is hoped that general agreement on fluoridation in that Board's area will then be extended to cover the Keswick supply.

The South Cumberland Water Board has agreed to the adjustment of fluoride in its supplies from the Ennerdale Water and Baystone Bank sources and again this will be co-ordinated with other work which is to be carried out. The Ennerdale Water scheme which is likely to be dealt with first, serves a population of about 60,000. As a preparatory measure the water is being analysed regularly so that there will be full information about the fluoride content and whether it varies in any way with climatic conditions. Similar background work has been undertaken in connection with the West Cumberland Water Board's supplies.

Implementation of the agreement reached with these two water boards will eventually lead to the adjustment of the fluoride content in the domestic water for a population of about 150,000 which is two-thirds of the population of the county.

It has been agreed with the Newcastle and Gateshead Water Company that the water which they supply to a very small area of Cumberland on the Northumberland border should be adjusted to the optimum fluoride level of one part per million.

Negotiations with the Carlisle and Eden Water Boards have not been successful but the foundations have been laid and it is hoped that, in the not too distant future, those boards may be prepared to re-open discussions. At the time when discussions were taking place with the Carlisle Water Board, Carlisle Borough Council had not expressed itself as being in favour of fluoridation. As most of the board's supply is to Carlisle the borough council's attitude must have influenced the water board's decision, but now that the borough council has decided to ask that the water supplies should have the fluoride content adjusted one looks to the future with rather more optimism.

So that the value of fluoridation may be assessed in the years to come a survey of the dental condition of children at the present time has been arranged. It is to be carried out by a research team of dental surgeons under Professor Jackson of Leeds University and they will collate information about the dental condition of several hundred children in different age groups from two comparable areas, one which is to have fluoridation and one which is not likely to have it for technical reasons for some time to come. I am most grateful to Professor Jackson for his assistance in this matter.

Child Welfare Centres

Since the time when an investigation into child welfare centres was undertaken in Cumberland in 1962 there have been certain well defined trends in the services offered at child welfare centres. These were foreseen at the time of the 1962 survey and have foreshadowed in its conclusions about the actual activities carried on in clinics. Certain developments in the child welfare clinics in the County have followed naturally from some of these conclusions; for example, the necessity which was apparent for a shift in emphasis in health education away from too much attention to quantitative nutrition and weighing, and towards urgent practical matters such as dental health. I am glad that now in the child welfare clinics in the County tooth brushes are in much greater prominence on sale than baby foods and supplements. Similarly, with regard to the medical activities at the clinic, the doctors are occupying their time more positively in the field of developmental observation and all use the excellent card designed for this purpose by the Society of Medical Officers of Health.

The progressive integration of local authority nursing staff with group practices has rather underlined the advantages of child welfare clinics being conducted in the setting of the group practice and I welcome every indication of increasing general practitioner interest in child health work. While the total number of attendances at local authority child welfare centres during the year was again a little down on the previous year (32,420 compared with 33,521) there were 367 sessions undertaken by general practitioners in their own surgeries involving an attendance of 4,329 children. In addition 43 of the sessions in local authority premises were conducted by general practitioners who are paid a sessional fee by the local authority for this work.

The appearance during 1967 of the Sheldon Committee report on Child Welfare Centres has therefore, in fact, done more to confirm the trends which have been apparent in Cumberland for some years than to suggest any fundamental change in the pattern of child welfare services. It is gratifying to see that one of the principal conclusions in this report is that the family doctor

should increasingly undertake the clinical work in the child health service of the future and in this should work closely with paediatricians and with local authority medical officers with special training and experience in certain aspects of child development and handicaps.

A major activity in child welfare centres has always been the provision of vaccination and immunisation facilities for pre school children. As is outlined in another part of this report these will in future be controlled largely through a computer as far as call-up arrangements to parents are concerned, and the call-up will normally be to a general practitioner surgery. Thus, yet a further child health service is rapidly becoming centred in the group practice. The new schedule of vaccination and immunisation which the Ministry of Health is now advising allows for all vaccinations and immunisations being given before school entry with the exception of the final reinforcement at the end of school life, when, in my view, young people should be encouraged to take some of the initiative themselves in securing this final reinforcement. All of this should make for more frequent and regular contact between the general practitioners and the pre school child—as of necessity, for immunising procedures—and this readily fits into a composite picture of child health care given by the family doctor. His gradual involvement in subsequent school health work again follows naturally.

The question of suitable premises for child health work, including the important health education aspects of the work, requires careful consideration. Local authority clinics in the past tended to be designed and built around the child welfare centre function. In future, buildings provided by the local authority will of course be health centres for group practice use and many of the present clinics will, no doubt, be adapted as has happened in Seascale for general practitioner team use. Again some group practices will prefer to provide their own improved premises and in all of these buildings I am concerned that adequate accommodation is provided for the supportive nursing team without which adequate child health services could not be conducted. Indeed accommodation, usually shared with other workers, should also be available

or such workers as speech therapists and physiotherapists—all rofessions concerned closely with child health work as well as ne wider provision of efficient community health services.

Thus the picture changes rapidly towards the child welfare linic conducted by the member of a group practice with special nterest in paediatrics; in the practice centre: and supported fully y attached local authority nursing staff. A key member of the atter team as far as child welfare work in concerned may well in uture be a new type of domiciliary midwife with an extended esponsibility for the health and development of young children. his theme is developed a little more fully in the section of this eport which deals with health visiting; an adequate child health ervice will only emerge with the full co-operation and backing of the whole family health care team.

The following table shows details of attendances at Child Welfare Clinics from 1958-67.

Attendances at Local Authority Child Welfare Clinics 1958-1967

Year	No. of centres provided at end of year	No. of child welfare sessions held per month at centre	No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
			Under 1 year	1 - 2 years	2 - 5 years		
1958 ...	19	88	1326	1192	1225	3743	18061
1959 ...	22	92	1596	1455	1389	4440	21947
1960 ...	22	95	1548	1408	1368	4324	22089
1961 ...	23	95	1603	1667	1704	4974	23004
1962 ...	27	96	1894	1625	2080	5599	27299
1963 ...	29	98	1901	1892	2007	5800	31948
1964 ...	30	106	2231	1965	2145	6241	35162
1965 ...	31	110	2322	2385	2285	6992	36852
1966 ...	33	119	2193	2185	2213	6591	33521
1967 ...	33	117	2080	1859	1890	5829	32420

CHILD WELFARE CENTRES, 1967

The following table gives particulars of the sessions and attendances at Child Welfare Centres throughout the County:—

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Northern Area					
Alston	Cottage Hospital, Alston	Wednesday	52	403	7
Anthorn	W.V.S. Welfare Office, Anthorn	2nd and 4th Thursday	23	299	13
Aspatria	North Road, Aspatria	Wednesday	51	844	17
Brampton	Union Lane, Brampton	Friday	50	1601	32
Dalston	Village Hall, Dalston	1st and 3rd Monday	39	731	19
Houghton	Village Hall, Houghton	2nd and 4th Wednesday	24	495	20
Hunsonby	The Institute, Hunsonby	1st and 3rd Thursday	19	488	26
Longtown	Esk Street, Longtown	Tuesday	49	1548	31
Nenthead	Doctor's Surgery	1st Tuesday	12	71	6
Penrith	Brunswick Square, Penrith	Tuesday	50	1624	32
Skinburness	R.A.F. Hut, Skinburness	1st Friday	8	45	6
Scotby	Village Hall, Scotby	1st and 3rd Thursday	23	284	12
Thursby	Church Hall, Thursby	2nd and 4th Monday	23	212	9
Wetheral	Village Hall, Wetheral	2nd and 4th Thursday	24	234	10
Wigton	Birdcage Walk, Wigton	Monday	47	1010	21
			494	9889	20

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Western Area					
Broughton	Nurse's House	3rd Wednesday	24	194	8
Cockermouth	Harford House, Cockermouth	Monday	47	1406	30
Crosby, Maryport	Nurse's House, Parkside, Crosby	2nd and 4th Wednesday	8	26	3
Dearham	Nurse's House, Central Rd, Dearham	4th Wednesday	15	111	7
Keswick	13-15 Bank Street, Keswick	Thursday	53	783	15
Maryport	24 Selby Terrace, Maryport	2nd and 4th Tuesday	50	1485	29
Seaton	Miners' Welfare Hall, Seaton	2nd and 4th Thursday	24	821	34
WORKINGTON—					
Park Lane	Park Lane, Workington	Wednesday and alternate Thursday	124	2959	24
Salterbeck	Holden Road, Salterbeck, Workington	Friday	51	1036	20
			396	8821	17

Centre	Address	Day	No of Sessions	Total Att.	Average Att.
Southern Area					
Cleator Moor	Ennerdale Road, Cleator Moor	Thursday	56	2206	37
Egremont	St. Bridget's Lane, Egremont	Tuesday and Thursday	100	2320	23
Frizington	Council Chambers, Frizington	Monday	49	1017	21
Millom	18 St. George's Road, Millom	Tuesday	53	2033	38
Seascale	Gosforth Road, Seascale	Thursday	84	1314	15
Thornhill	Community Centre, Thornhill	1st and 3rd Wednesday	24	614	26
WHITEHAVEN—					
Flatt Walks	Flatt Walks, Whitehaven	Monday and Tuesday	52	1853	36
Mirehouse	Dent Road, Mirehouse, Whitehaven	Monday	47	1322	28
Woodhouse	Woodhouse, Whitehaven	Wednesday	50	1028	21
			515	13710	27
		GRAND TOTALS	1405	32420	23

Family Planning

The authority has continued its policy of not directly providing family planning facilities in the county but rather supporting the Family Planning Association in various ways with its activities including placing premises at their disposal free of charge. The Association held clinics in the local authority child welfare centres at Millom, Penrith, Workington and Whitehaven, in Alston Cottage Hospital and in Carlisle in premises made available by Carlisle Borough Council. It had been hoped to start a clinic at Aspatria but staffing difficulties have so far prevented this.

In July the Ministry of Health issued circular 15/67 advising authorities on the implementation of the National Health Service (Family Planning) Act, 1967. Briefly, this Act confers on local health authorities a general power enabling them, with the approval of the Minister of Health—which was in fact given generally in the circular—and to such extent as he may direct, to make arrangements for the giving of advice on contraception, the medical examination of persons seeking such advice and the supply, by prescription or directly, of contraceptive substances and appliances. The Act extended the existing powers of authorities to enable them to provide or arrange for other bodies to provide, as their agents, advice on contraception and supplies for persons who need them on social grounds and not as previously only in cases where pregnancy was likely to be detrimental to health.

Following consideration of this circular the authority decided to provide a family planning service as empowered under the National Health Service (Family Planning) Act, 1967, and that the Family Planning Association should be asked to act as agents in providing the service which initially would be available at Alston, Aspatria, Carlisle, Millom, Penrith, Whitehaven and Workington. At that stage no decision was taken as to whether there should be a charge for prescriptions given or drugs or appliances supplied in non-medical cases, but it seemed likely that the full economic cost would be charged. Unfortunately, before further action could be taken to establish this family planning service financial exigencies, coupled with the Government's request that no new

services should be begun, lead to the withdrawal of the financial provision. The service will, therefore, continue to be provided by the Family Planning Association with restricted assistance from the authority.

I am pleased to include the following report from the Secretary of one of the Family Planning Association's clinics in the county:—

"The Family Planning Association clinic in our town is one of the smaller ones which make up the Lakeland Branch. It was started in 1959 by a voluntary committee of local women concerned for the welfare of their community. Its aims have always been "To help married women plan their families, to give advice in cases of sub-fertility and to help in medical difficulties connected with marriage relationship". The Executive of the Family Planning Association made an initial loan for the establishment of a clinic, which functioned first in a private house and since 1960 by courtesy of the Health Department in the County Council clinic, where seven members of the original committee, including nurse, still take an active part in the work.

"One hour sessions are held twice monthly and patients write or 'phone for appointments, although we try to accommodate all callers as soon as possible. Some are advised to come by their family doctors, some given our address by the hospital after a confinement, by a Health Visitor or friend, or have seen our notice in the local press. New patients are interviewed initially by experienced receptionists, and necessary details noted for obligatory statistics, although it is explained that strict confidence is maintained with regard to names and circumstances. Nurse is responsible for arrangements made for the smooth running of the clinic, and all patients are seen in private by the woman doctor for consultation, examination and advice as to appropriate methods, with further instruction by nurse in the use of the method chosen. Patients return to the outer rooms where fees are paid, supplies bought and membership cards marked, record

card filed and appointments made for check visits. Patients on oral contraceptives must return for check and further prescription at least every three months, and cap patients return after a few weeks for further teaching and check visits; at the least an annual check visit is recommended though all members may consult doctor as often as they wish. Pre-marital patients are seen by doctor within three months of the date of the intended marriage and return a few weeks afterwards for check. Our committee does not regard advice to the young unmarried as part of "Family Planning" and has decided not to undertake this. Cervical smears are an important part of the work of the clinic, taken in all "pill" cases and family practitioners informed of results as a matter of courtesy.

"The official session over, voluntary lay workers at the supplies table balance the cash and sessions sheet (some headaches here), check and pack away supplies and the toys provided for the small children of waiting patients, whilst in the medical rooms nurse and her helper strip down examination couches, re-arrange screens and furniture, empty the sterilizer and lock up equipment. A welcome cup of tea, a chat, and we disband for another fortnight, carrying white coats to wash and mail-order parcels to post. A session of one hour for our members entails an hour's preparation and another clearing up afterwards: the clinic runs on the professional services of doctor and nurse and the voluntary help of the band of lay workers who form alternating teams. Both doctor and nurse have undertaken special training by the Family Planning Association for this work, and courses are arranged for lay workers also."

The Organising Secretary of the Lakeland Branch of the Family Planning Association, Mr. S. Camm, makes the following comments on the service in 1967:—

"Prior to the Family Planning Act being brought into being it was considered that our Family Planning Association clinics would considerably increase the number of new patients with the result that it would have been necessary to open ad-

ditional clinics, and areas with suitable clinics had been discussed. Since the above Act came into operation it has been found that more and more general practitioners are offering this service to their patients, and the number of referrals by local authorities has only slightly increased, with the result that the anticipated flood of new patients has not materialised. General practitioners are also taking cervical smears for their patients with the result that local authority clinics are not now receiving the number of patients anticipated.

"The treatment of the unmarried is still undecided as all clinics have not yet declared their attitude to this subject. Various methods of treating the unmarried are in operation and no woman will be turned away from our clinics without first receiving the advice of the doctor".

It is interesting to see that the Secretary considers that there is already a trend towards general practitioners offering more in the way of a family planning service as I believe that this is the way in which the service should progress in the future. This is an aspect of family health care and I would expect, in the long term, it to be undertaken by the family health care team. It is after all a socio-medical problem and it seems to me that it should be dealt with alongside other problems of the family and not in isolation.

Nurseries and Child Minders

The Nurseries and Child Minders Regulation Act, 1948, placed a statutory duty upon local health authorities to maintain a register of, and authority to supervise

(a) premises (i.e. day nurseries) in their areas, other than premises wholly or mainly used as private dwellings, where children are received to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days, and

(b) persons (i.e. child minders) in their areas who for reward receive into their homes children under the age of five years to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days.

The authority does not itself run any nurseries but at the end of the year there were twenty privately run nurseries registered for the care of 513 children. This was an increase of four nurseries and 157 children on the 1966 situation. In addition three child minders were registered for the care of 50 children, a decrease of one minder and 25 children compared with 1966. In total there were, therefore, facilities for the care of 132 children more than in the year before.

The new registrations were in Abbeytown, Anthorn, Distington and Wigton, and the following table shows the localities of the registrations and the maximum number of children provided for.

Northern Area	Western Area	Southern Area
Abbeytown — 20	Cockermouth — 50	Distington — 30
Anthorn — 20	Crosby — 15	Egremont (2) — 60
Brampton (2) — 50	Portinscale — 20	Millom — 30
Dalston — 20	Seaton — 30	Seascale — 10
Longtown (2) — 36	Workington (2) — 50	St. Bees — 10
Penrith — 35		Whitehaven — 32
Scotby — 20		
Wigton — 25		

Each of the registered child minders or nursery organiser is provided by the authority with the booklets—"Play with a Purpose" and "Not Yet Five"—recommended by the Ministry of Health as suitable guides about their activities. These provide some basic initial guidance for the organisers who are visited regularly and advised by the Area Medical Officers and health visiting staff.

The facilities provided by day nurseries and child minders are, without doubt, of great value to both the mothers and the young children who attend them; particularly in the case of only children, learning to mix socially with other children is of great importance and the companionship gained is invaluable. Attending a nursery or play group also helps considerably when the transition to full time school takes place.

For many mothers it is a great boon to have their children looked after for a few hours each day while they are doing housework or shopping, secure in the knowledge that their children are happily occupied and well looked after. Both mothers and children are likely to benefit appreciably from this service, a service which is expanding rapidly as a comparison with 1965 figures show. At that time there were only eight registrations catering for 150 children.

Marriage Guidance Councils

In the field of community health and welfare the work of the marriage guidance councils is of great importance in the prevention of breakdown of marriages. The presence of a strong marriage guidance council is an invaluable asset to the community and is a perfect example of an effective and complementary voluntary service working alongside the statutory social welfare services.

In addition to the preventive or remedial counselling offered to those people whose marriages are in difficulty, the field has widened to include education for engaged couples. Furthermore the youth counsellors of the Carlisle, Cumberland and Eden Valley marriage guidance council have been very active during the past year, their four counsellors making visits to schools in Kendal, Windermere, Keswick, Seascale, Maryport, Penrith, Wigton, Brampton and Carlisle. Here small group discussion sessions with older school children are skilfully guided and the young people can learn much on inter-personal relationships by self expression and exchange of ideas.

Financial support is given on request by the County Council to the marriage guidance councils operating within the administrative county by way of an annual grant, and free accommodation is made available at Park Lane Clinic, Workington, to the Carlisle, Cumberland and Eden Valley Association.

The Catholic Advisory Council have during the year ceased to operate but this is a temporary measure only and it is anticipated that the Council will be active again during 1968.

The following table indicates the number of new problem dealt with annually since their establishment:—

Year	Carlisle, Cumberland & Eden Valley Council		Catholic Advisory Council	Total
	Carlisle	Workington	Carlisle	
1961	49*	—	—	49
1962	57	—	—	57
1963	55	19*	18	92
1964	15	36	15	66
1965	39	39	3	81
1966	42	17	2	61
1967	28	14	—	42

* Part year only

The Secretary of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council has kindly supplied the following report on the work of the Council during 1967:—

"During the year the Marriage Guidance Council made steady progress. We were fortunate enough to recruit four new Counsellors and towards the end of the year they all passed National Selection; two or them have completed their initial training and are counselling at our Carlisle headquarters. This is a real step forward and gives promise of an even better service in 1968.

"In 1967, 42 couples received guidance and our Education Counsellors held 173 sessions of Group Work; 165 with young people in schools; 3 with Youth Clubs; 2 with Nurses and 3 with Apprentices. We are indebted to the Cumberland County Council for their financial support and the use of accommodation in Workington."

VACCINATION AND IMMUNISATION

Section 26 of the National Health Service Act, 1946

"Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox and the immunisation of such persons against diphtheria"

VACCINATION AND IMMUNISATION

After a number of years in which the County Council scheme for vaccination and immunisation against certain infectious diseases proceeded with little change, several new factors are now evolving and giving rise to re-planning the scheme in several respects. I have commented in previous reports on the desirability of the use of a computer in processing data in this field and especially in streamlining the call-up of children at the required intervals for immunisation procedures due. The beneficial effect of this on the community level of protection is well established in other areas. We are now moving more certainly towards this in Cumberland and I hope the year 1968 will see the details of such a scheme finalised. Also the new Ministry of Health arrangements for recording and paying for immunisation work carried out by family doctors came into operation in 1967. Not surprisingly this has resulted in 45% of all vaccination and immunisation work being done in 1967 by the general practitioners compared with 40% in the previous year. I expect to see the proportion undertaken by general practitioners increase steadily as they undertake more work in the child health service, i.e. in child welfare clinics and the School Health Service.

In addition to all of this a modified schedule of vaccination and immunisation throughout childhood is being produced by the Ministry of Health and a measles vaccination scheme has just been announced by the Minister. Clearly a very close working arrangement is necessary with the general practitioners in this field and I am glad that the Local Medical Committee has appointed representatives to discuss with me all of the detail which will have to be worked out.

The role of the nursing team in the work of vaccination and immunisation has also been further discussed and clarified during the past year. A simple statement of the nurses' responsibility has been arrived at, emphasising that the clinical decisions on the suitability of an individual to receive a specific antigen rests entirely with the doctor while the nurse is responsible for her own practical technique of administration. I am glad that it has

been possible to keep to a minimum, regulations and instructions on this subject. The important thing is that the team work of the doctor and nurse has been extended in a helpful and logical way in this vital preventive health field. It is the advice of the Ministry of Health that smallpox vaccination should be given by a doctor, and similarly measles vaccine in the early stages of that scheme.

In the latter part of the year a very useful opportunity was afforded one of the staff of the department to appear on Border Television on the subject of vaccination and immunisations and to stress the importance of maintaining a high level of protection.

Diphtheria Immunisation:

The numbers of children immunised during the year were as follows:

Primary courses—pre-school children	3,095
Primary courses—school children	1,130
Reinforcing Injections—pre-school children ...	1,841
Reinforcing Injections—school children	4,930
TOTAL ...	10,996

The figures in the above table are very similar to those for 1966 and represent a reasonable level of childhood protection against diphtheria. In future, according to the new schedule of immunisations there will be no need for a reinforcement injection against diphtheria and tetanus at ten years of age. Thus many 'school entrant' children might well be given their reinforcement at that stage by the family doctor, thus reducing the amount of time actually spent in school on immunisations. In that case a close watch will have to be kept on the protection level from month to month. At present it can be fairly closely calculated how many children will be protected, according to the allocation of school medical officer time in schools.

Whooping Cough Immunisation:

The number of children who have completed a primary course of whooping cough immunisation during 1967 was 3,098 and 1,261 received reinforcing injections. These figures run closely parallel, of course, with those for diphtheria and tetanus protection in infancy. A rather difficult decision, within the terms of the new schedule of the Ministry of Health, will be the timing of the initial 'triple' (diphtheria, whooping cough, tetanus) injection in infancy. Hitherto it has been aimed at the second or third month in order to secure early protection against whooping cough, but it is pointed out that a better immunological response follows initial injection at six months. Many doctors will no doubt wish to continue to ensure the earlier protection against whooping cough.

I show on page 124 a graph of notification of whooping cough from 1940-1967. From 1952/53 onwards when a proved whooping cough vaccine was available the notifications, though erratic from year to year, began a general downswing. When the Triple antigen came into more comprehensive use in the County in 1960 and ensured routine parallel whooping cough protection along with that against diphtheria and tetanus, the result was a dramatic reduction in notifications.

Tetanus Immunisation:

The total number of children receiving protection during 1967 was 11,084 a small increase of 325 over the figure for 1966.

The following table shows more detail:—

Primary courses—pre-school children	3,082
Primary courses—school children	1,221
Reinforcing injections—pre-school children ...	1,854
Reinforcing injections—school children	4,927

Protection against tetanus and diphtheria go hand in hand and it is reassuring in a rural agricultural community to observe the build up of resistance to this disease. Unlike most of the infections against which the community is protected by immunisa-

tions, tetanus does not spread to produce epidemics. An individual protection derives entirely from his or her personal immunisation The scheme continues for notifying the accident hospitals and th family doctors of all children immunised against tetanus.

Smallpox vaccination:

The following table shows the number of children who hav been protected against smallpox during the past seven years. A small but gratifying increase is again shown. In contrast t tetanus, smallpox is, of course, a disease in which the genera level of community resistance counts for a great deal if a epidemic threatens. Thus every pressure possible must be kep up to ensure a high level of immunity throughout the population It should always be remembered too, of course, that regular re vaccination is ensured for such as medical, nursing and ambulanc personnel, liable to come into contact with any case of smallpo which might occur.

Year	Age under One year	Age One year	Age 2—4 years	Total
1967	266	1,284	334	1,884
1966	300	1,160	364	1,824
1965	464	893	210	1,567
1964	594	742	119	1,455
1963	786	208	80	1,074
1962	2,150	322	428	2,900

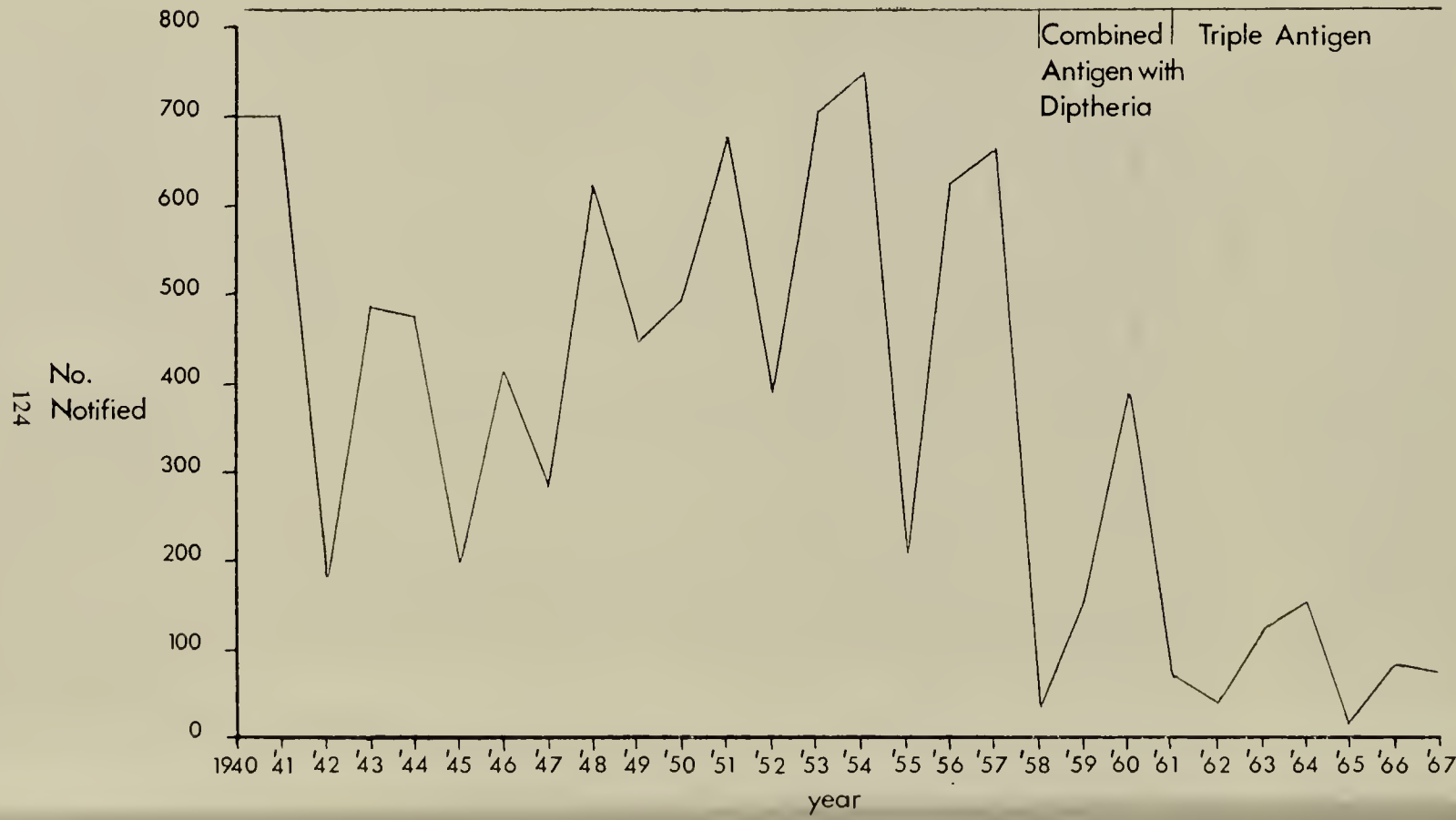
Poliomyelitis Vaccination:

Primary courses—pre-school age	...	3,215	(3,147)
Primary courses—school age	...	1,426	(1,597)
Reinforcing doses—pre-school age	...	106	(119)
Reinforcing doses—school age	...	2,715	(3,626)

The figures shown above indicate a similar level of protection for poliomyelitis as for diphtheria. The County has now had its 4th year free of any confirmed cases of poliomyelitis. This undoubtedly flows from a satisfactory level of community protection and depends on this for future security.

Measles Vaccination:

By the time this report is presented to the Health Committee the 1968 measles vaccination campaign recently announced by the Minister of Health will be well under way. The aim will be to protect by a single injection of live attenuated measles vaccine all children up to 15 years who have not previously had measles or been vaccinated against it. This further excellent investment in child health for the future comes at an opportune moment when it can be integrated to the new schedule and the computer programme. It is hoped that a summer campaign will substantially modify the measles epidemic due towards the end of this year in the usual biennial occurrence pattern.



WHOOPING COUGH NOTIFICATIONS — CUMBERLAND 1940-1967

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946

"A local health authority may, with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness, the care of such persons suffering from illness . . , or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the managements."

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946, is expressed broadly and covers many local authority services which are not specifically mentioned. Some of these, for instance marriage guidance and family planning, have for convenience been dealt with elsewhere in this report but there remain other services which cannot be easily categorised with welfare, home nursing, health visiting, etc. They are, therefore, collected together in this section of the report which covers the services provided for cervical cytology, the care of those in the community suffering from tuberculosis, the provision generally of equipment on short term loan to patients being nursed at home, domiciliary physiotherapy, convalescence following illness at home, chiropody and health education. Separate sub-sections are devoted to reports on each of these services.

HEALTH EDUCATION

Health education—the helping of people to maintain their health and encouraging them to take an interest in their physical and mental well-being—can be approached in many different ways. There is the giving of advice on specific preventive measures such as vaccination and immunisation; talks with a view to improving habits and attitudes which prevent disease and improve health; making the public aware of all the available health services both statutory and voluntary; encouraging the use of these services when necessary and especially, the seeking of advice at the right time. All are carried out individually and collectively and frequently illustrated with films and posters.

The close liaison which now exists between general practitioners and their attached nursing and health visiting staff has eased the tension which sometimes existed about health education. Educative work with individuals can be undertaken in fuller confidence that the family doctor is not only aware of what is being done but that he is in accord with the general intentions.

Filmstrips are still the most popular media for the introduction or illustration of a talk but the authority has built up a considerable number of 35 m.m. colour slides depicting all aspects of the health and welfare services in the county which are proving most useful for general talks.

The uninspiring bread-and-butter work of health education—the issuing of pamphlets, posters and other literature—has gone ahead and whilst time-consuming it still provides probably the main outlet of information to the public. Display boards and flannelgraphs are widely used to better illustrate the main points and frequently health visitors use their own materials to illustrate and bring home specific points.

The following table shows the number of talks given and attendances in 1967:—

	Talks	Attendances
At clinics	133	1,600
At schools	238	6,500
Mothercraft and relaxation classes ...	360	2,700
Mothers' clubs, W.I. meetings etc. ...	90	1,600
	821	12,400

While there were rather fewer talks to groups than in the previous year the total audience increased.

It is probably about time for a re-appraisal of the health education in schools, where the approach is, I think, rather narrow. More emphasis needs to be placed on the hazards to healthy living now affecting the middle age groups. The large number of cases of heart disease, the increasing incidence of malignant disease associated with cigarette smoking, the prevention of dental caries by the adjustment of the natural fluoride content of public water supplies and many other salient up-to-date facts and figures should be given to children in order that they may have the choice of the best of knowledge to run their lives in as healthy a manner as possible.

Mothers' clubs continue their good work and the secretary of the club at Brampton reports:—

> "We have been fortunate in securing the services of speakers in a wide range of topics, and it is this aspect of our meetings which the members find both interesting and helpful in relation to the upbringing of their children. One example of this was when Dr. Elderkin, Consultant Paediatrician at the Cumberland Infirmary, emphasised the dangers of aspirin and iron poisoning which was a fact not fully appreciated by the majority of our members. The subject matter ranges from talks by local police officers to more specialist matters such as a visit by Mrs. McLean, of the Marriage Guidance Council, who advised members on sex instruction

for young children. On one occasion we organised a public meeting in the Irthing Valley School, Brampton, for a visit by Mrs. Gibson, of the National Childbirth Trust. A film entitled "Birth of a Baby" was shown, illustrating the psycho-prophylactic method".

Also on the work of Mothers' clubs, this time at Workington Miss J. Surtees, a health visitor, writes:—

"During the year, meetings continued twice a month. Programmes have been as varied as as possible and include work of the Public Health Officer, First Aid revision, talks by the nutritional experts, and cookery demonstrators, the dishes being raffled afterwards.

"Films shown covered every aspect of child development up to the fringe of adolescence "Obese Child", and "Distressed Child", showed where parents can go wrong, but how they can be helped and the importance of parents communicating with their children. Travel films included Europe—Russia with commentary of life, the people and industry in that country. Beauticians demonstrated care of hair and styling, care of the skin, mothers themselves being models. Flower arrangements and gardening have been proved as a valuable way to mental relaxation.

"A milliner showed new hats for all the year that can be made at minimal cost.

"Recently a film, and talk, was given by the local librarian on the history of the town up to the present day and was much appreciated".

To the staff who can be accommodated in general practitioners' surgeries a further opportunity for health education is opened up, as Miss A. Jackson, a health visitor in a family health care team in Workington reports:—

"The practice to which I am attached has a monthly ante-natal clinic in the surgery and for the past two years I have been in attendance there for the purpose of talking with

ante-natal women while the doctor and midwife carry out the examinations. The talks are informal, rather than prepared ones, as there is rather a lot of coming and going. My visual aids must be easily transportable. I have a small blackboard at the surgery and carry posters and charts etc. On one occasion I used half a pear to depict the uterus and a pipe cleaner twisted into shape was used to demonstrate the foetus in utero.

"I explain why the various examinations are carried out and their importance. I talk about diet, posture, the layette, preparations of breasts, breast and bottle feeding, the composition of breast and cow's milk, various kinds of dried milk, mixed feeding, hygiene etc.

"Sometimes a film is shown relating to hospital and home confinement and I encourage the women to ask questions. Discussion is not always easy, as many women are shy. To introduce a light note I have had one or two sessions on "Old Wives' Tales". A box was passed round, each woman picked out a paper and read out a question on some silly fallacy. This gave me the opportunity of giving the correct and common sense answer. I have discussed with my midwife colleague the possible of getting the ante-natal mothers from the other surgeries together for one or two sessions with special speakers. This we hope to arrange."

There is still a need for a special health education officer but aving spent a fairly considerable sum of money on advertising ithout success it has been decided to leave the appointment in beyance for the moment.

CERVICAL CYTOLOGY

1967 was the third year during which a cervical cytology service had been provided in Cumberland and, as expected, the demand showed a fall. In 1965 the service was being taken up slowly, expanded rapidly during 1966 when a total of 4,062 smears were taken by local authority staff, then fell to 1,730 smears in 1967.

The service has continued to be available at the clinics at Carlisle, Brampton, Penrith, Wigton, Cockermouth, Maryport Salterbeck, Workington, Whitehaven, Cleator Moor and Millom but, in view of the falling demands, sessions have been held as and when required, rather than universally on predetermined dates. In addition a domiciliary service has been provided where it seemed to offer the best solution to the problem of getting co-operation from those who were felt, after consultation with general practitioners, to be especially at risk. Only half as many smears were taken in this way in 1967 compared with 1966—72 against 155—but, nevertheless, it is a valuable part of the service and one which should continue. An interesting development has been the taking of smears in general practitioners' surgeries by the local authority nursing staff attached to the practices and, in fact, 23% (391) of all smears were taken in this way. Even more interesting is the fact that this surgery based service produced positive smears at the high rate of 12.8 per thousand compared with a rate of 5.6 per thousand from smears taken in clinics and no positives from the domiciliary service. This latter was most surprising as experience elsewhere, and previously in Cumberland with the domiciliary service, had suggested that as high a "yield" of positives as 20 per thousand might be expected. However, the number of domiciliary smears taken in 1967 was so small that no statisically sound data could be expected from them.

The twelve positive smears taken in the service in 1967 gave an overall rate of 6.9 per thousand compared with 5.9 in the previous year and a national rate of 6.4.

The results of all smears taken in local authority clinics or in women's own homes are notified direct from the laboratory to each of the women concerned. To enable this to be done with

minimum of clerical help at the laboratory a pre-addressed nvelope accompanies each smear, the envelopes having been ad- ressed by the voluntary helpers at the clincs. At periodic intervals atches of copies of notifications of the negative smears are sent) the general practitioners so that they may be kept informed of ıe situation as it affects their patients. Where smears are ositive or suggest the need for further investigation, or even treat- ıent for some other condition, the notification is sent direct from ıe laboratory to the general practioner and it is his responsibility) contact the patient and explain the situation. In such cases no otification is sent from the laboratory direct to the patient. These rrangements seem to be working well and consideration was iven to their extension to cover the results of smears taken t Family Planning Clinics. It was thought that there may e some embarrassment on various grounds and it was, there- ore, decided that in general the results would be sent to the amily Planning Clinic where the smears were taken and that he individual women would be notified from there, general ractitioners being informed only in the case of positive smears r when there was need for investigation or treatment for some ther conditions.

All the cervical smears taken through the local authority ser- ice have been taken by nursing staff. This was generally accepted y the consultant obstetricians and gynaecologists. However, at a neeting with representatives of general practitioners appointed by he Local Medical Committee, gynaecologists and pathologists, the iew was expressed that local authority doctors should take the mears in clinics. No action has yet been taken on this suggestion s it is thought that cervical cytology will, in fact, become a general ractitioner service, but it is interesting to note that where large umbers of smears have been taken by general practitioners they ave, in fact, been making use of the local authority attached nurs- ng staff for this purpose.

The group of doctors which meets each year to consider the levelopment of the service also considered the decreasing demand. t was agreed that more publicity seemed to be necessary but the acts demonstrated that advertising in the local press had little

effect. A considerable amount of money spent on advertising brought virtually no increase in the demand for the service. As an alternative it was, therefore, decided to increase the display of posters and to extend this to general practitioners' surgeries and chemists' shops. In addition I wrote to all branches of the Women's Institute and Townswomen's Guild drawing attention to the facilities available and providing leaflets to be handed out to their members. Following this a number of the Institutes invited nurses to attend their meetings to discuss cervical cytology and answer any questions which members had. I am grateful to the Women's Institute for their co-operation in giving this service publicity.

The group also considered the introduction of the Ministry of Health's standard record card and rejected it. While this rejection raises no immediate problems it does pose one for the future. A most valuable purpose of the standard form was to enable women to be recalled for further smears by the use of a computer on a national basis. This has been one of my main concerns about the local arrangements; the fact that so far as I can see periodic recall is not going to be easily achieved. This is a matter which will have to be weighed carefully in any future consideration.

I believe that the future will see a steady increase in the provision of the service by general practitioners and their attached local authority staff so that eventually the local authority clinics will be providing a service only for those whose general practitioners are not giving the service or who, for other reasons, do not wish to attend at their doctor's surgery. This, I think, will be to the good of the service as it will be in line with the general movement towards the general practitioner and his team assuming full responsibility for patient care.

Tuberculosis and Diseases of the Chest

Once again the Consultant Chest Physicians in East and West Cumberland have provided me with copies of their annual reports. These are included as appendices to this report. The importance of the continuing vigilance of the Chest Physicians in

the matter of tuberculosis is obvious so long as this disease is still a problem though happily a diminishing one. The rather sombre annual increase in numbers of cases of lung cancer being dealt with at the Chest Clinic casts a shadow over the wonderful progress made in chest diseases in recent years.

Dr. Morton in his report on the mass radiography unit draws attention to the disappearance of the mobile unit and the future concentration on the three static units at Carlisle, Workington and Whitehaven. This in itself reflects the great change in the community situation with regard to tuberculosis. A mobile unit from Newcastle could be brought in for any special survey purpose which might become advisable in Cumberland.

Thus the work of the Chest Clinics continues in close collaboration with family health care teams in the community and thanks are due to Dr. Hambridge and Dr. Morton once again for all their wonderful co-operation in the after care responsibility for tuberculous and other chest cases which fall to the local health authority.

Nursing Equipment on Short-Term Loan

A total of 511 items of equipment were issued on a short-term loan during the year to patients being nursed in their own homes of which 467 were major items. The following table shows the range of equipment which is now being made available.

Equipment	Items issued during 1967	1966	1965	1964	1963
Commodes	129	141	145	105	98
Crutches	31	31	62	65	34
Hoists Hydraulic ...	3	—	—	—	—
Hospital Beds	7	12	10	22	9
Invalid Chairs—					
Adult type	127	167	176	134	141
Junior type ...	9	5	22	8	7

Mattresses—						
Rubber	8	14	15	21	20
Inflatable	—	3	3	8	3
Tripod Walking Sticks ...	153	159	150	130	127

With the increasing developments in total patient care outside of hospital the demand for loan equipment is bound to increase. During the year the service has continued as in previous years to be very efficiently run on behalf of the County Council by the British Red Cross Society who issue equipment from three depots, one of which is situated in each of the three administrative areas, as follows:—

CARLISLE—

2 Chatsworth Square, Monday-Friday, 10 a.m.—12 noon.

WORKINGTON—

59 Station Road, Tuesday and Thursday, 10 a.m.—12 noon.

WHITEHAVEN—

Whitehaven Hospital, Tuesday & Thursday, 10 a.m.—12 noon

ORTHOPAEDIC SERVICE

During 1967 both the physiotherapists employed by the County Council left the Council's service. Both Miss Morris and Miss Fraser had given wonderful service, especially to the children of the county, and more especially to those who were afflicted in days which are happily past, with bone and joint tuberculosis and poliomyelitis. The departure of the two physiotherapists has been associated with a complete re-appraisal of community based physiotherapy work. A great deal of the work with children which they carried out in the past will in future be looked after either at hospital specialist clinics or by remedial gymnasts in schools.

The emphasis of the work of community based physiotherapists in the future seems clearly to be as members of the family health care team led by the general practitioners and so the first stage of replacement of the physiotherapists has been the employment of two part-time therapists in Brampton and Seascale, both areas where there is a firmly established family health care team led by a group of general practitioners. It is clear already that these physiotherapists are doing an important job of work in the team, and the help which they can give to selective patients both at home and in the group practice centres often spares the patient a tiresome journey to a hospital physiotherapy department.

I am very glad to include now a report by Mrs. Bratt on the first six months of her work with the Seascale practice. Mrs. Bratt writes:—

"This appointment was for twelve hours per week to be divided up to the advantage of patient and physiotherapist. Two sessions of visiting in the mornings and two sessions at the clinic in the afternoons were carried out, with the variation of evening visits to the schoolchild or patients who are not at their best in the morning. The advantages of a mobile unit, and a small out-patient department have been combined to serve this rural area where travelling long distances to reach the West Cumberland Hospital is either impossible or a hardship to patients. The post has proved more arduous than one in a large hospital because of the responsibility of working alone but results have been on the whole encouraging. Close co-operation with the doctors and district nurses in the practice has been invaluable."

Visiting Sessions

The large size of this group practice means patients are widely scattered, and an average of forty-five miles has to be covered to treat five or six, but this apparent waste of time is offset by the value of treating certain patients in their own homes. Although cases may be broadly classified, as in Table II, no two are exactly alike, and treatment consists of giving re-education, encouragement and advice on the problems which face each patient. Techniques of proprioceptive neuromuscular facilitation are used whenever indicated.

Orthopaedic and hemiplegic cases are visited as soon as they return from hospital and, after discussion with the physiotherapists who attended them as in-patients, rehabilitation continues progressively. This follow-up treatment is re-assuring to the patients and they improve steadily.

Home visits are definitely indicated in hemiplegia as even the young tire easily and require all their stamina for half-hour periods of intensive re-education, without the effort of travelling to Whitehaven. The handicapped child and his mother also benefit from home treatment.

Once the child has got used to the routine he is relaxed at home, and the mother can be supported in her day-to-day problems of looking after him. There are many chronic conditions of the elderly which may be relieved by spells of treatment. Some are visited once a month, and those fit to travel can be brought into the clinic by ambulance, which saves time.

Clinic Sessions

Many minor injuries and conditions are referred immediately by the doctors, and can be cleared up in a few attendances. The average length of treatment is four to six weeks, sometimes longer according to necessity.

Acute muscle and joint conditions, chronic rheumatic conditions, and re-education of function following fractures, having formed the bulk of the work. See Table II.

Obviously the Clinic is not equipped as a physiotherapy Department, but much has been achieved with the aid of a Megatherm Portable Short Wave Diathermy Unit, and a Hanovia infra-red lamp, both on loan. A thermostatically-controlled Wax Bath is also in use. Pulleys, weights, goniometer and steam pack have been supplied by the Whitehaven Health Department on request.

TABLE I

Analysis of Monthly Treatments

	No. of visits	No. of attendances at Clinic
October ...	58	52
November ...	45	44
December ...	46	27 (off one day)
January ...	52	55
February ...	51	51

To maintain the February numbers, the time is divided into eight hours per week for visiting, and four hours per week at the clinic. More than twelve hours per week are sometimes needed to do the work, and at the moment there is a short waiting list.

TABLE II

Analysis of Conditions treated

Acute muscle and joint conditions	13
Chronic rheumatic conditions	12
Re-education after recent injuries and fractures	7
Re-education after orthopaedic operation	4
Chronic conditions of the elderly	4
Multiple sclerosis	4
Cerebral Palsy	2
Long standing hemiplegia	2
Recent hemiplegia	2
Flat foot exercises	2
Breathing exercises and postural drainage	3
Total number of patients treated	55

Opinions vary professionally as to the wisdom of employing physiotherapists outside hospital. I believe, however, that this situation has to be carefully assessed in the light of the operation of a successful family health care team which has secure links with hospital departments where physiotherapy treatment may well be started for patients who live at a considerable distance from the hospital. Certainly the initial reaction in this authority of the physiotherapists themselves and of the doctors and nurses with whom they are working, suggest that an important job in this field is needing to be done in the community. It will also be remembered that with physiotherapists as with other professional groups there will always be married ladies prepared to work at convenient and agreed hours in the community-based team who would not be in the position to consider hospital work. The scheme commenced in the two years mentioned above will continue to be considered carefully in conjunction with the doctors concerned in the group practice.

CONVALESCENCE

The authority continued its arrangements for convalescent care for adults but, because of the financial situation, there was more rigorous selection of cases. As a result, the number who benefitted from the scheme was reduced to half the number in 1966 and one third of the 1965 total, as the following figures show:—

Convalescent Home	1963	1964	1965	1966	1967
Silloth	51	83	141	97	48
Others	1	—	3	2	1

In considering this sharp reduction in cases it is relevant to bear in mind that a comparison with other authorities in the north of England had shown that when the Cumberland figure was at its highest the rate of admissions here was five times that in other areas. In that light, the reduction which has been made is not unreasonable. Selection of cases was by consideration of the pre-disposing illness and its effect on the household as a whole, always taking account of the over-riding requirements of the Home and the recommendation of the general practitioner. Although nursing staff and skill are available in the Home, primary selection of cases by the family doctors is directed towards referral of those who require the minimum of medical care. All must be ambulant and, of course, capable of deriving benefit from the facilities provided.

The convalescent home of choice has naturally been Silloth Convalescent Home. It is well established in many respects—in its pleasant situation on the Solway coast, in climatic conditions that are generally mild and agreeable to most cases, in its accessibility by road at any time of year, and by reason of its excellent reputation in care, comfort and consideration. The Home is registered as a Nursing Home under the Nursing Homes Act of 1963, is run on a non-profit making basis under the guidance of an active committee whose meetings I or my deputy attend, and is well staffed by matron, nurses and ancillary staff.

There were a number of cases where elderly persons were recommended for convalescence but on investigation were found to need no nursing care and probably no convalescence in the generally accepted meaning of the word, but where the remainder of the household would undoubtedly benefit from a short respite from providing constant care and attention. Such cases were admitted to the authority's own short stay and holiday home at The Towers, Skinburness, not far from Silloth Convalescent Home.

CHIROPODY SERVICE

The free chiropody service for the elderly, the physically handicapped and expectant mothers continues to meet an increasing need, although the increase in 1967 was considerably less than in any previous year since the service began. The nett increase in patients was 5% to a total of 5,965.

Of these patients, 27% were certified by their general practitioners as being in need of domiciliary treatment. This is about the same as in 1966. One wonders why, with areas of roughly equal population, no less than 41% of all patients live in the Western Area compared with 32% from Northern Area and 27% from Southern Area.

The service is available to three priority groups of patients but in practice almost all—more than 99%—come within the category of elderly. If this category is taken to mean men of 65 years of age and over and women of 60 and over, about 18% of all the elderly in the administrative county get free chiropody treatment.

It had been hoped that with the return of Mrs. J. Glaister from training the full time staff would be up to the establishment of six. Unfortunately, Mrs. Glaister's arrival coincided with Mrs. Coulson's resignation and it has so far not been possible to fill the vacancy. This leads to difficulty in the Western Area but towards the end of the year it had been agreed to second full time chiropodists from the Southern and Northern Areas to help out. I am pleased to report that the chiropodists readily accepted these arrangements.

In addition to the establishment of six full time chiropodists the authority has arrangements with thirteen chiropodists in private practice for them to see patients under the county scheme in their own surgeries, at the patients' own homes or to undertake clinic work on a sessional basis. At the end of the year the full time staff were responsible for treating a total of 3,343 patients, while 2,622 were treated by the part time staff. On the assumption that

about 550 patients constitute a case load for a full time chiropodist the part time members of staff are in total equivalent to 4.8 full time.

Treatment continues to be available at the following places, no new centres having been opened in 1967:—

Alston	Maryport
Aspatria	Millom
Brampton	Penrith
Carlisle	Salterbeck
Cleator Moor	Seascale
Cockermouth	Silloth
Egremont	Whitehaven
Keswick	Wigton
Longtown	Workington

Chiropodists also visit all the authority's Old People's Homes.

From time to time when considering matters in connection with the chiropody service in the past, I found myself without any reliable information as to the amount of their time the chiropodists actually spent on treatment, travelling, etc.

The chiropodists themselves could only guess at probable figures and we, therefore, agreed that some form of survey to get accurate information would be most useful. On practical grounds it was felt that the survey should be limited to full time staff and that it should be undertaken in two-week periods. An analysis of the detailed records kept specially for the purpose during the periods 13th to 24th February and 6th to 17th November shows that on average 65% of the time is spent on treatment, 14% on travelling, 11% on clinical work and 10% on "other duties". This latter category covered the time spent preparing and cleaning up surgeries, dealing with enquiries and the time wasted due to patients arriving late, broken appointments, abortive domiciliary visits, etc.

The amount of time spent on travelling is, at first glance, quite high. However, when it is considered that over a quarter of all patients have to be visited at home and that in this county such visits can involve substantial mileage, the 14% becomes not unreasonable. Nevertheless, it is a figure which illustrates the price to be paid, both in chiropodists' time and travelling expenses, to see patients at home rather than in the clinic. This matter is constantly engaging the attention of all concerned and general practitioners are reminded from time to time of the need for special care in authorising domiciliary treatment.

The amount of time which the highly trained chiropodists spend on routine clerical work has been investigated more closely and I am satisfied that these functions have been reduced to the absolute minimum. Whether it would be better to employ part time clerical assistance to release chiropodists for their true functions has also been looked at carefully but in general the clerical work is carried out in many short periods, such as when patients are dressing and undressing, and to have other staff to do this would not, in fact, make the chiropodists available to do much more chiropody.

So far as the wasted time is concerned, it is constantly impressed on patients that if they cannot keep appointments the chiropodist should be given as much notice as possible, but I think it must be accepted that, as we are dealing with the elderly, a fair amount of wasted time is inevitable, especially during periods of inclement weather.

I believe there is general agreement that the chiropody service is one of the most worthwhile services provided, and certainly one of the most appreciated. There is, however, controversy as to whether it should be a completely free service and it is of interest to note that this authority is one of only six counties where it is free.

The service has its problems, not least of which is transport. If that problem could be overcome a better service could, I am sure, be provided, but even among the chiropodists themselves there is a divergence of opinion as to how it might be achieved, as the following comments show:—

Mrs. J. E. Glaister, M.Ch.S., S.R.Ch., the authority's most recently qualified chiropodist reports:—

"The main aim of the chiropody service in the care of this group (the elderly) is the maintenance of mobility. In the main, correction in these patients is not possible as joints become arthritic and immobile, and treatment must take the form of amelioration of the immediate discomfort and the prevention of further disability. Constant padding is necessary but prolonged applications of adhesive to ageing skin is harmful; therefore, a more permanent form of protection is required. The answer to this lies in replaceable pads, insoles, and more ideally later type appliances. These are made by the chiropodist, fitted to the patient and last for up to two years. A clinic could be quite easily fitted with the various pieces of equipment necessary for the production of such appliances and used by the chiropodist when necessary. In the long run this would constitute an economy in the service.

"Transport difficulties and other factors have resulted in an increase in the number of domiciliary patients and in a rural county such as ours this can be difficult for both patient and chiropodist. An answer to this difficulty is the provision of transport to the clinic for these patients. I believe that the voluntary services are co-operating in the provision of transport and I feel that if this could be extended, the service could be greatly improved."

Mrs. G. Garrett, M.Ch.S., S.R.Ch., considers that:—

"The provision of a chiropody service in rural areas by a mobile unit would be of very great value where bus services are irregular. Clinics could be run in rotation in outlying villages, with domiciliary cases arranged en route. During the last war, in the Edinburgh area, a converted ambulance was used with great success. I feel this method of reaching scattered patients would be less expensive and more convenient for both patients and chiropodists alike, rather than attempting to bring patients in by car service to a clinic. There is a lot of wasted waiting time for patients and sometimes for drivers

with this method, and I think the mileage would probably be less in the long run. This mobile unit could be used to provide a school service; visiting each school say at least once a year and providing inspection and advice. This is an area of chiropodial work in which there is great scope, as it is one field in which true preventative chiropody can be used."

At staff meetings the future of chiropody has been discussed and in this connection I am pleased to record the views of Mr. J. H. Thomas, M.Ch.S., S.R.Ch., the authority's first full time chiropodist, and Mr. W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N. Mr. Thomas writes:—

"The chiropodist who has successfully completed the recognised course of training is a specialist fitted to take his place in the general medical team and make a valuable contribution to patient care.

"The demand for chiropodists exceeds this availability.

"It follows that the chiropodists should be employed to carry out the work for which he has been trained and not be burdened by those duties which could be carried out by lesser skilled persons. These include clerical duties and simple pedicure. It also follows that the amount of time spent on unnecessary travel as for example on non-essential domiciliary visits must be reduced to the minimum. This means that whenever possible patients should be seen at a central treatment centre with the provision of transport if necessary. In the future I think it will be necessary to introduce further qualifications other than a purely arbitrary age qualification for patients seeking treatment, based on their medical background. For example, two fields of medicine where the chiropodist can make a valuable contribution are the management of the advanced rheumatoid arthritic and in the management of the diabetic patient."

Mr. Gordon reports as follows:—

"With the development of health centres, which are intended to facilitate co-operation between different branches

of the Health Service, the chiropodist is given an opportunity to play a full part in contributing to the health and welfare of the community.

"The need for an expanded chiropody service for the elderly now appears to be generally accepted.

"If something could be done to ensure that fewer and fewer old people are incapacitated by their feet, a great deal of time, money and skill could be saved.

"Chiropody within the School Health Service is a necessary prerequisite if a serious attempt is to be made to control the rising incidence of crippling foot conditions among the adult population and the elderly. Working within health centres, the pre-school examination of children's feet would prevent the onset of many foot conditions and offers scope for more liaison with physiotherapists and nurses. There is a need for advice to parents and children on footwear, as a means of preventing foot conditions in later life.

"More foot health education could be done by chiropodists.

"Facilities for appliance therapy could be extended. Pads and specially constructed insoles skillfully made, can compensate for many deformities both congenital and acquired.

"There is a need for constant research into possible new techniques with new materials—appliance therapy is an integral part of the chiropodist's training and could be utilised to provide worthwhile results.

"There could be chiropody clinics for high risk patients with under-lying medical conditions who need intensive care, such as diabetes, peripheral vascular disorders and rheumatoid arthritics.

"These are a few of the ways in which chiropody could be expanded within a re-organised health service.

"In outlining the need for chiropodial care for children, the emphasis attempted has been on chiropody as a preventive service.

"A great number of conditions which chiropodists treat in the elderly patient could have been prevented or at least the affects avoided if only they had been examined soon after the symptoms developed or become established."

Undoubtedly, prevention must be our aim, but in the present financial and staffing circumstances it looks as though the priority groups will continue to be the elderly, the handicapped and expectant mothers and that treatment will be limited to those groups. It is unfortunate that in footwear in particular, health education seems to make little progress against the dictates of fashion.

WELFARE SERVICES

WELFARE SERVICES

It is difficult to pinpoint any specific focal point of development in the welfare services for the elderly and handicapped, but there has been notable progression in the re-orientation of services and the redeployment of resources to meet more effectively the increasing demands of a rapidly changing social situation.

The fusion of health and welfare services came about in Cumberland four years ago when attempts were also being made to unify community care of the patient by the attachment of local authority nursing staffs to general practitioner groups. In other sections of this report, I have commented on my satisfaction at the speed with which this concept of the general practitioner ed "family health care team" has been proved and accepted. Thus almost without realising its accomplishment, this simple but far reaching betterment of service to the needy in the community has been achieved to the extent that every health visitor and district nurse is working in attachment to a family doctor or group of doctors. The social welfare officers (who also undertake mental welfare duties) are an integral part of this family health care team, so that the health visitor and social worker can between them, in consultation with the family doctor, supply him with whatever socio/medical services his patients may require. Coupled with this close association in the home situation is the firmer liaison which continues to develop with the hospital services at all levels—between the hospital consultants and the local authority's medical officers in their role of non-clinical community physician, between the hospital ward sister and the local authority's area nursing officer, and between the hospital based medical social worker and the local authority's social welfare officer. No single part of the National Health Service can function in isolation since all are inter-dependent upon each other, and it is only by the closest co-operation and integration of services that the full spectrum of care can be achieved.

Many authorities which have responsibilities for community social work services of every kind have naturally shown some reluctance to expand these services or to re-organise the work

of skilled officers to meet changing social situations, because an effort they may make along these lines may later be found to b in conflict with national policy. I refer, of course, to the fact tha the Seebohm Committee which has been studying the variou social work agencies has not yet reported its findings. This Com mittee's recommendations, if acceptable to, and implemented b the Government, may well result in the establishment of a separa department within local government which will have responsibiliti for a wider range of social work functions than is required undc present legislation of Health and Welfare Departments, and ma include duties at present undertaken by, for example, the Chil ren's and Education Welfare Departments.

It is fortunate that in Cumberland positive steps were taken t unify the various social work functions within the combined Healt and Welfare Department, and that the first moves to link thes with the nursing and general practitioner services were starte before the Seebohm Committee received its mandate. My advic to the Council will be to continue this policy of the developmer of the family health care team approach, including the soci welfare officers, for the support of the disabled, handicapped, an elderly in the community with the family doctor as the co-ordinato of effort, until there is a declared change in national policy fc the social work services.

RESIDENTIAL ACCOMMODATION

(a) For the elderly

At the end of 1967 there were 427 beds available within the county to provide residential accommodation for the elderly who are "in need of care and attention which is not otherwise available to them". The types of welfare accommodation can be divided into three main categories:—

Joint-user establishments	(2)	115
Adapted premises	(5)	113
Purpose-built Homes	(7)	199
		427

The national policy is to provide services from statutory and voluntary sources which will enable the elderly to remain in their own homes, but if this is impossible or impracticable the residential provision must be developed to meet the need.

Locally the Council's policy is directed towards relatively small units built to modern standards of comfort and amenity on a "neighbourhood" basis, so that the old person can remain close to relatives, friends and the community in which they have been living. An integral part of this policy is that the former Public Assisance Institutions (now "Joint-user establishments" with the hospital authorities) shall be replaced as soon as circumstances allow.

The following table shows the manner in which this policy has developed:—

At 31st December	Number of beds provided			
	Joint-user establishments	Adapted premises	Purpose-built Homes	Total
1952	325	—	—	325
1953	325	19	—	344
1954	325	19	—	344
1955	263	69	—	332
1956	263	69	—	332
1957	242	69	—	311
1958	242	113	—	357
1959	252	113	—	365
1960	215	113	38	366
1961	215	113	38	366
1962	117	113	114	344
1963	117	113	114	344
1964	117	113	114	344
1965	117	113	149	379
1966	117	113	189	419
1967	115	113	199	427

During 1967 a small Home (10 beds) was opened at Aspatria in association with a grouped dwelling project by the Wigton Rural District Council of ten bungalows which offer supported independency to up to twenty elderly tenants. Within the Home are communal Welfare facilities for the occupants of the bungalows, and the matron of the Home acts also as warden to the grouped dwellings. This is the second enterprise on this pattern in Cumberland, and I feel that there is much to commend this joint action between the County Council in fulfilment of its welfare functions and that of the District Council as a housing authority in recognising the need for special forms of housing with welfare support for the elderly.

By the end of the year two new Homes were nearing completion—one at Penrith (40 beds) and the other at Longtown (20 beds). These two developments, providing a total of sixty beds,

will enable the Part III accommodation Joint-user establishment at Station View House, Penrith, to be closed, with a nett gain of five beds. Only one former Public Assistance Institution at Highfield House, Wigton, will then remain in use.

Ministerial approval having been obtained, it is hoped to begin building new Homes at Millom, Keswick, and Wigton, before the end of the financial year 1967/68. The Millom Home was originally scheduled as providing only ten beds, linked to a small supported independency development by the District Council, but this was up-graded to a more economic unit of twenty-five beds. This is thought to be adequate to meet the local need in this rather isolated part of the county area, and at the same time will allow The Croft, Kirksanton, either to be closed or used in some other direction in which its isolation and structural deficiencies will not be so restrictive. The proposed Keswick Home is an additional provision of twenty-five beds in a delightful and very practical location. The opening of the Wigton Home is eagerly anticipated, marking as it will the closure of the last of the former Public Assistance Institutions in this county.

At the time of writing, this carefully programmed development may be at hazard because of the impact of the national economic situation on local authority expenditure. Present indications are that the ceiling for expenditure in the financial year 1969/70 will be not more than three per cent above that allowed for 1968/69. Since the completion of these three Homes would require an increase in revenue expenditure of somewhere in the region of ten per cent it may not be possible to go ahead with all these projects.

Looking ahead to the earlier part of the capital development programme, and on the basis of ascertained need in the various parts of the county, it was decided to include new forty bedded Homes at Workington in the 1968/69 programme, and at Whitehaven in 1969/70, and the Minister has indicated that he is prepared to recommend loan sanction accordingly. The present recommendation is that two more units of forty beds each at Cockermouth and Cleator Moor should be included in the 1970/71 programme.

The increasing physical and mental handicaps of the present day resident of our welfare Homes present mounting problems of organisation within the Homes and necessitates continual revision of design standards. Most of the residents have some degree of osteo-arthritis which makes movement painful, difficult and slow. Many are dependent on wheelchairs, or walking aids, about six per cent are blind and many more have only partial sight. Almost fifteen per cent suffer from nocturnal incontinence, five per cent are incontinent during the day and about three per cent are doubly incontinent. The majority have some degree of mental deterioration or confusion, and nearly three-quarters are on some form of sedative or tranquillising drug.

This overall picture of increasing infirmity means that the use of adapted premises with stairs and no lift becomes more and more limited. Even the modern, purpose designed Homes only a few years old are now short of dining space because of the number of residents in wheelchairs. Bathrooms and toilets do not provide the space which is needed to allow an attendant (and sometimes two) to help the more disabled residents. Failing visual acuity demands higher standards of illumination particularly in corridors and circulation areas.

(b) **For the Physically Handicapped**

There is a tendency to think of local authority accommodation provided by the welfare authority only in terms of the aged, since the vast majority of the provision caters for the needs of the elderly. The duty of the authority to persons in need of care and attention is clearly laid down, and includes those whose need for residential care springs from "infirmity or any other circumstances". Cumberland's first Home for the physically handicapped is nearing completion at Maryport, and provides comfortable single rooms for twenty residents, together with workshop and recreational facilities. Much thought has gone into the details of design because of the variety of disabilities which are expected. This hostel will meet a need in respect of the younger people in the community who suffer from severe disabling conditions.

and will allow some who have been maintained at the authority's expense in similar accommodation outside the county to return to Cumberland.

Out-County Provision

A local authority may, of course, arrange for the residential care of persons who normally live within its area in Homes provided by other local authorities or by voluntary agencies. The following Cumberland residents were accommodated in such Homes at the end of 1967:—

Local Authority Homes	Male	Female
Lime House. Wetheral	1	1
Elizabeth Welch House, Carlisle ...	1	—
Stannington, Northumberland ...	—	1
Staveley, Westmorland	1	—
Hoylake, Cheshire	1	—
Brigg, Lincolnshire	1	—
Steeton, West Riding	—	1
	5	3

Voluntary Homes

British Legion Home, Ripon ...	1	—
Percy Hedley Centre, Newcastle ...	2	1
Distressed Gentlefolks Home, Harrogate	—	1
Maghull Home, Liverpool ...	2	1
Scalesceugh Home for Spastics, Carlisle	3	1
Church of Scotland Home, Campbeltown	—	1
Ernest Ayliffe Home for the Deaf, Leeds	1	—
Cheshire Home, Windermere ...	—	1
Eothen Homes, Whitley Bay ...	1	—
Methodist Home for the Aged, Liverpool	1	—
Charles Best Home, Cheshire ...	1	—
Langho Colony, Blackburn ...	—	1
Ostley Home, Barrow	1	—
Eventide Home, Somerset ...	1	—
	14	7

Towards the end of 1965 the Ministry of Health issued a memorandum to local authorities and hospital authorities on "The care of the elderly in Hospitals and Homes" outlining the functions of the local authorities and Hospital Boards respectively in providing care for elderly persons. In issuing the memorandum, the Minister requested that both authorities should review their

services in the light of the principles laid down in the memorandum, and urged the desirability of setting up joint consultative machinery for the purpose of these reviews and for the continuation of co-ordinated planning for both services. Meetings covering the areas of both the East Cumberland and West Cumberland Management Committees were held in 1966, and both were followed up by similar meetings during 1967. These meetings with those responsible, both clinically and administratively, for geriatric hospital services and representatives of the general practitioners' services have been invaluable in directing policy and forward planning along co-ordinated lines. Apart from the careful consideration of statistical trends which affect the future provision, I think the following points which have emerged during the meetings are worth recording:—

(a) Admission to welfare accommodation is increasingly via geriatric hospital assessment units. With close co-operation and liaison between the hospital service and the local authority's officers there is much better understanding of the problems involved between the two services.

(b) Arising from (a) above, there is perceptively more mobility between the hospitals and welfare Homes.

(c) The expectancy of life in a welfare Home is diminishing and is now down to about two and a half years on average. This is largely due to good community care services which enable old people to remain in their own homes longer than had previously been possible. The increasing cost of supportive domiciliary services, especially domestic help, is causing some anxiety.

(d) Following pilot surveys undertaken on a general practitioner group practice basis of the population aged seventy and over, it is proposed to visit old people at the age of seventy-five to assess what possible social or medical needs exist. It is hoped thereby to take necessary action to prevent social isolation and health deterioration in the elderly.

Staffing of Residential Accommodation

The long awaited report of the Committee of Enquiry set up by the National Council for Social Service under the Chairmanship of Professor Lady Williams which has been enquiring into "The recruitment and retention, training and field of work of the staff of residential accommodation other than hospitals, designed for persons in need of care . . . . " was published in book form entitled "Caring for people" during the year. This exhaustive study following a factual survey of the present staffing position reveals what is described as a crisis situation. Salient points in relation to care of the elderly in residential Homes to be considered are:—

(a) Because of the expected increase in the proportion of very old in the community it is estimated that the number of staff required in residential Homes for the elderly will increase by more than fifty per cent within ten years.

(b) The survey reveals that the service still depends largely on single women—over eighty per cent of care staff are women, nearly two-thirds of them are single, and more than half of them are over fifty years of age. There is no longer a pool of single women to take over from them.

(c) The annual wastage of care staff for local authority Homes is twenty-five per cent.

(d) Only fifteen per cent had any formal qualification.

(e) There is at present no career structure, no recognised qualification, and no ladder to higher status.

The conditions which are highlighted in the Williams' Report were to some extent anticipated in Cumberland rather more than two years ago when the Council approved a scheme which was devised as a long term measure to overcome difficulties in filling more senior posts in welfare Homes by the introduction of a trainee scheme. Although in the early stages some difficulties were encountered in recruiting suitable young women, the scheme has gained in success as it has become more established, and towards the end of the year it was possible to promote one of the

ainees to an assistant matron's post at one of the smaller Homes. he recruitment of suitable staff to care for the elderly in resi- ntial Homes becomes increasingly difficult year by year, and e Williams' Report which is based on an extensive survey con- ms my belief that a reasonable long term approach to this oblem is by the promotion of a career structure through train- g. After considering these matters the Council accepted my re- mmendation that the number of trainees (who are regarded as pernumerary to establishment) should be increased from three six, but unfortunately at the time of writing the financial imate is such that this further development may have to be post- oned.

Even when it is possible to recruit candidates with appropriate aining and experience, and since the senior posts require that ie occupants shall be resident, they cannot be expected to stay nless the quarters provided for them fully meet their family eeds and measure up to modern standards of amenity and com- ort. Resident staff quarters in welfare Homes have tended to be ar too easily accessible to the residents with the inevitable result hat the matron has little privacy for herself or for family life, nd can never be completely "off duty" except when she leaves ie premises. These difficulties are commented upon in Lady Villiams' Report, and they have for some time been the subject f discussion at the quarterly meetings of matrons of welfare Homes. However, with the help of the County Architect, accom- nodation for senior resident staff is being planned which will nable them to enjoy family life in adequate quarters.

Temporary Accommodation

Accommodation for the temporary housing of persons who have become homeless for a variety of reasons, ranging from bad management of their affairs to sudden misfortune is provided in Cumberland in a building within the grounds of Highfield House, Wigton, which has three family units, and a single house located at Harriston, Aspatria.

At the beginning of the year, four families including seventeen children in all were living in these units. During the year one family absconded, leaving all their possessions (most of which had been supplied from welfare and voluntary sources) and a number of local debts. The husband of another family deserted the home, but one family (man, wife and four children) were successfully rehoused. One family of husband, wife, and four children, were admitted to temporary accommodation having been found stranded by the police in Penrith following their eviction from a relative's home in Scotland where they had been sub-tenants. Accommodation was provided at the Harriston house for a family of husband, wife, and three children, who found themselves homeless when the tenants of property which they owned nearby refused to leave. These moves meant that at the end of the year, four families with a toal of fourteen children between them were occupying temporary accommodation provided by the welfare authority.

The authority's statutory responsibility in providing accommodation for the homeless is one which is fraught with difficulty and frustration. Those whose homes are burned down or flooded are clearly eligible for help since their need arises "in circumstances which could not reasonably have been foreseen", but the vast majority of homeless coming to notice find themselves without accommodation because of their own fecklessness or lack of foresight. When a local eviction seems likely because of rent arrears an "early warning" system comes into operation through the District Council and it is sometimes possible, where children are involved, to bring into play a rent guarantee scheme with the help of the Children's Officer to prevent the eviction. Co-ordinated action between many different authorities must be taken

) prevent the tragedy of homelessness arising, and to ensure that amilies becoming homeless are treated with sympathy and under-tanding. It has been my experience in Cumberland that most t those accommodated come within the category of "problem amilies", and are usually homeless because of rent arrears. Their esettlement in permanent homes from temporary accommodation rovided by the Council is largely dependent on the willingness f the District Councils (as housing authorities) to regard these eople as acceptable tenants. Since so many of them have amply emonstrated that they are quite incapable of managing their nances or of coping with their family responsibilities, a long and ften unproductive process of social rehabilitation must be under-aken in the hope that their claim for permanent rehousing will be ore favourably received. This process demands a great deal f co-ordinated effort by social workers, nurses, and voluntary gencies, and the results are often so disappointing that the officers oncerned wonder if their time could not have been used more rofitably in other directions.

Miss Welch, the senior social welfare officer in the Northern rea of the county has been closely associated with the rehabilita-ion of homeless families and reports as follows:—

"Homeless families frequently arrive from a distance or have taken possession of derelict buildings as squatters, and for these reasons no housing authority will accept responsibility for them. The only hope of rehousing is to persuade one of the District Councils to become interested and sympathetic. To this end we use all our available rehabilitative resources. A health visitor does intensive visiting to give advice on the care and cleanliness of the children. The family home help is instituted free, where necessary, and will give periods of help with housework for two hours on three days a week during which she aims to work with the mother to demonstrate good household management. At the end of the year we had one family home help of this type visiting a family in the temporary accommodation at Highfield House who had developed a very happy relationship with the children and was well accepted by their mother. The accommodation pro-

vided is quite small and does not really need much management to keep it clean and tidy, but the establishment of the routine of home management, and education in the preparation of suitable meals is difficult, especially with a fish and chip shop nearby. The social welfare officer visits regularly to allow parents to discuss their problems and so relieve feelings of injustice which inevitably arise when they can get neither housing nor work, and to try to direct their thoughts towards making appropriate efforts for themselves to better their conditions.

"The accidental death of an eight month old baby in its pram at the Wigton Units was distressing but no blame was attached to the mother.

"There are also difficulties over payment of the small rents which are charged for temporary accommodation. The families have either acquired the habit of getting into debt over rent, or have lived in a rent free tied cottage so that the habit of regular payment for rent is not easily established. In one case, the husband had absconded and although he was sending money regularly to keep his family at levels above those laid down by the Ministry of Social Security, there have been odd occasions when the allowance was not received. At one stage it was suggested that proceedings should be instituted for a legal separation, but the husband threatened to stop the allowance completely if these proceedings continued. This woman receives a bigger allowance from her husband than she would receive from the Ministry of Social Security but she is still not able to manage her financial affairs very well and the debt for rent tends to increase."

In a rural area unless temporary accommodation is made available on a wide geographical basis a further complication may be the necessity to move a family from their normal area of residence and employment. This then is a rather gloomy situation, in which many of the difficulties at present appear to be intractable. The joint circular from the Ministry of Health, the Home Office and the Ministry of Housing and Local Government, which was

issued in September summarises the reports made by local authorities in response to an earlier circular. If the County Council (as the welfare authority) were not so dependent on the District Councils for the rehousing of families from temporary accommodation the availability of emergency accommodation would be much greater, and the movement of rehabilitated families to permanent housing would be very much easier.

Registered Homes

There remain three Homes within the administrative county which are registered by the County Council under the provisions of Section 37 of the National Assistance Act for the reception of disabled persons or old people. These are at:—

Rothersyke, Egremont	(11 residents)
Spring Bank, Braithwaite	(10 residents)
Scalesceugh, Nr. Carlisle	(30 residents)

Rothersyke and Spring Bank cater for the elderly seeking private accommodation, whereas Scalesceugh is run by the Cumberland Westmorland and Furness Spastics Society for adult spastics. All these Homes are subject to regular inspection by members of my staff.

One Home (Stoneleigh, Gosforth) which had been functioning as a private Home for the elderly since 1955 was closed in June 1967, on the retirement of the proprietress. I was happy to be able to assist in finding alternative accommodation for those residents remaining in her care.

The number of enquiries I receive for private care for the elderly (as distinct from that provided by the local welfare authority) suggests that an opportunity exists for the establishment of more Homes offering this form of service in the area.

One clause in the Health Services and Public Health Bill at present before Parliament provides a welcome extension of powers, for which experience has shown the need, in enabling local authorities to accommodate the elderly and the handicapped in registered homes run privately as well as in local authority or voluntary homes as at present.

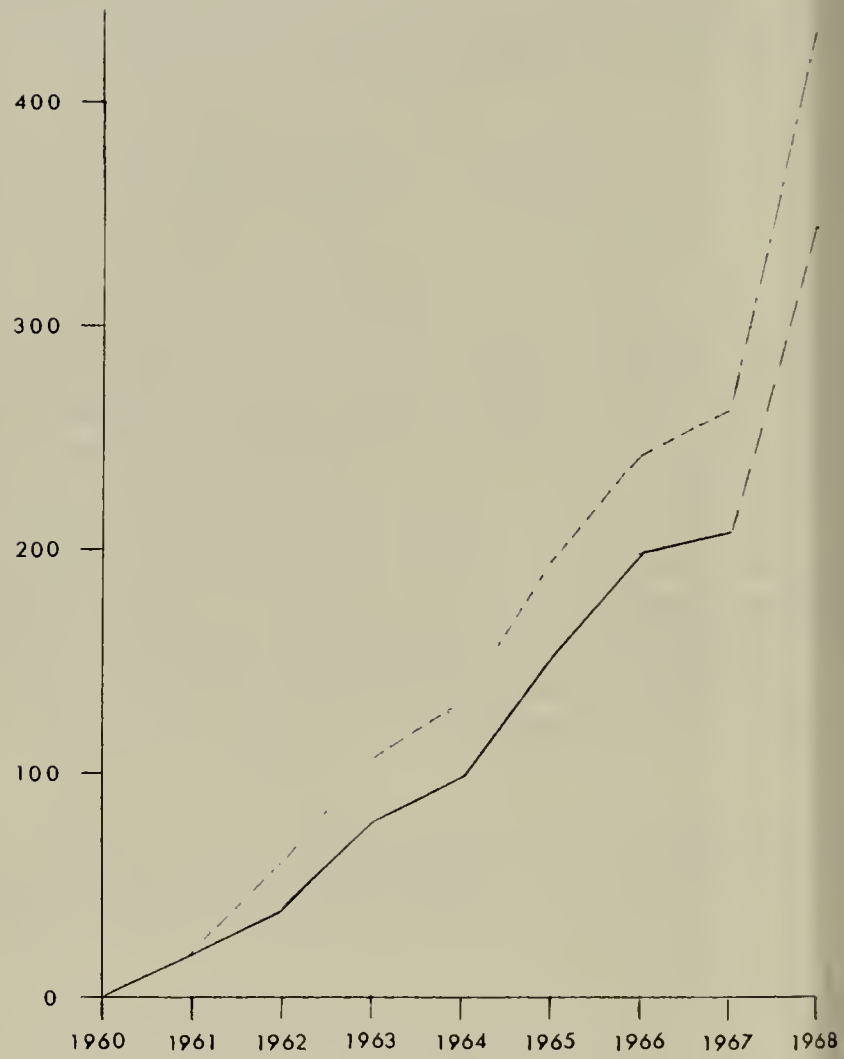
Supported Independency Schemes

The provision of special housing in grouped dwellings with warden oversight for the elderly is a fairly recent innovation in the County. In retrospect, therefore, it is most encouraging to note what has been achieved in the short time which has elapsed since the first scheme in Cumberland was opened at Keswick in December, 1961. The period of rejection which often accompanies new ideas was fortunately of short duration in this case, and there followed an increasing demand for these schemes as they became known and accepted. There does not appear to be a national "norm" for the rate at which this form of care should be made available in support of the elderly, but even if such a yardstick existed it would obviously be subject to considerable variation by purely local factors such as the level at which general council housing was available for the older members of the community, family mobility, the strength of family support (this being of particular significance in a rural county suffering serious outward migration of its younger people) and the availability of supporting domiciliary services.

The following graph illustrates how these schemes have developed over the last seven years:—

Special Housing for the Aged

Supported Independency Schemes



	1960	1961	1962	1963	1964	1965	1966	1967	1968
units:-	0	20	40	79	99	152	198	208	
places:-	0	20	60	107	131	194	242	262	

——— units

– – – – places

— — units (projected figure)

— · — · — places (projected figure)

Only one new scheme came into operation during 1967—at Aspatria 10 two-person bungalows were provided by the Wigton Rural District Council in association with a small residential Home for the elderly. The matron of the Home acts also as warden to the grouped dwellings, and the bungalow tenants enjoy communal facilities (provided by the County Council) within the old people's Home. The year was noteworthy in the number of schemes:—

(a) Agreed between the County Council and District Councils

(b) Where preliminary negotiations between the two authorities have been successfully completed as a result of which formal approvals will shortly be forthcoming.

In the former group, a block of twenty flatlets with communal facilities and warden oversight is nearing completion at Maryport, and at Millom the building of ten bungalows in association with a new residential welfare Home will begin in March, 1968. It is, therefore, confidently expected that a further 136 units of accommodation of this type providing up to 172 places will become available for occupation in the near future.

An interesting feature of these developments has been the variety in design of the individual units of accommodation and in the general layout of the grouped dwelling scheme as a whole. There are now within the county grouped flatlets physically attached to a small residential home, a detached bungalow scheme closely associated with a welfare home (mentioned above), separate blocks of flatlets converging to a focal point in the communal accommodation and so on. It is most encouraging that the District Councils seem anxious to consult with my department and associated departments of the County Council in the design of the housing units to ensure that the total scheme measures up to the needs of the potential tenants. By stages it has become more obvious that "shared" facilities for bathing or toileting purposes are no longer acceptable and in the more recent developments each housing unit has its own bath and W.C. so that the shared accommodation is reduced to communal lounges and facilities for laundering and drying. I hope that the District Councils will

continue to exercise their ingenuity and be prepared to experiment still further in the design and layout of these schemes.

There is no doubt in my mind that the contribution made by these schemes in the spectrum of care of the elderly will assume an even greater importance in the future. Our aim as a welfare authority must always be to create a climate which will enable our elderly to remain within the community, if at all possible. Undoubtedly the vast majority will, with such support as may be necessary from statutory and voluntary sources to supplement that of relatives and friends, enable them to live out their lives in comfort and security in their own homes—indeed it is confidently expected that 96% of the elderly will be able to remain at home. Because of infirmity and/or social difficulties a small proportion will inevitably require a degree of care which can only be given under the full residential conditions which are provided in the welfare Homes. Coming between these two are those who may be living in unsatisfactory circumstances because their homes lack certain basic amenities or have difficult stairs which can no longer be managed by an old person. Others may be at hazard because of social isolation or because their location makes the provision of even modest supportive services well night impossible. Unless accommodation which meets their needs is available they quickly become candidates for full care in a residential Home, but given the opportunity to enter a grouped dwelling community they can retain a greater measure of independence, enjoy all the amenities of a home which has been specially designed to cater for the special requirements of an elderly tenant in complete privacy or with companionship at will, with the opportunity of knowing that help is quickly available at any time if it should be needed.

There is accumulating evidence from the senior social welfare officers (whose duties include the support of the mentally disordered in the community) that elderly people with mental depression seem to do well under supported independency conditions because the privacy and liberty which they require, the therapeutic value of company and the security of warden support are readily available at will. I would like to close this section by quoting the comments of one of the tenants (aged 76) of the Manor Court

flatlets scheme at Cockermouth who prefers to remain anonymous. He accepted the offer of a flat when he was living alone in a converted railway carriage at some distance from shops and other amenities. "I suffer from a heart condition and it was very difficult to manage in the caravan even with the district nurse coming in and the home help. Now I enjoy a ground floor flat and the warden is there if I should need her. My flat is comfortable and centrally heated. I can now do my own shopping in Cockermouth and no longer need any domestic help. I feel so much more secure and independent and I have been glad to accept the Chairmanship of the Social Club at the flats".

Handicapped and Disabled Persons

The numbers of registered handicapped persons at the end of each of the last five years were as follows:—

1963	...	...	278
1964	...	...	342
1965	...	...	415
1966	...	...	517
1967	...	...	614

There is no evidence that the incidence of permanent and substantial physical handicaps in the community has more than doubled within the space of five years. The reason that so many more are now coming within the full range of health and welfare community services lies in the fact that their physical and social needs are no longer being inadequately dealt with in isolation but through a continuum of service by the family health care team working alongside voluntary agencies in the community. The family doctor, with his clinical responsibility for the patient, has the direct support of his attached nurse and also of social workers whose particular function is to bring into play any ancilliary service which will lead to a fuller life for the handicapped person and his family. The most significant increases in registrations have continued amongst those who have undergone an amputation, those who suffer from arthritic or rheumatic conditions and those who suffer from nervous diseases of organic origin such as disseminated sclerosis or the affects of a stroke.

Apart from the obviously practical requirements such as the provision of aids to make life more comfortable for the physically handicapped, the development of clubs makes a valuable contribution in drawing the disabled together so that they can enjoy social intercourse which would otherwise be denied them. At the same time the clubs also provide an effective focal point of contact with the welfare services and the medium for broadening the members interests within the limits of their disability by diver-

ional crafts, outings and many other social activities. Only one new club was opened during the year—at Aspatria for a full day each week. There are now 9 centres for this form of activity throughout the County—some open for a full day each week, others for two half days according to local demand and the availability of suitable premises. The Council provides two centres which are available on a full time basis for all forms of handicapped—one purpose designed at Workington and the other an adapted building at Whitehaven. Use is also made of local authority clinics, establishments for further education and rented premises. I cannot speak too highly of the generous support from voluntary workers in helping to run these clubs. Without the efforts of so many people ranging from busy housewives to eager school children it would be quite impossible to offer such wide facilities from the local authority's resources alone. This is real community service where positive voluntary effort is so visibly supplementing the statutory provision with its limited availability of man power. Apart from the very practical assistance which they give, these volunteers demonstrate that the community does care about and wishes to be involved in, the welfare of the less fortunate. Regretfully I must report that a serious limiting factor in the further development of this service is beginning to show itself. Very few of those who attend the clubs are able to use public transport because of their disability and whilst private cars from voluntary sources are used as much as possible, the numbers of severely handicapped who can only travel in some special form of ambulance transport is beginning to exhaust the resources of the ambulance service. This represents only one facet of the difficulty so far as the ambulance service is concerned because it has similar liabilities for transporting people attending day hospitals, outpatient clinics, day centres for the elderly and some of the very severely handicapped children who are attending training centres for the subnormal and who cannot travel by any other form of transport. I feel that the time is rapidly approaching when serious consideration must be given to relieving the ambulance service of these increasing commitments—possibly by the acquisition of some form of special transport for the severely disabled and in particular those who are confined to wheelchairs or have gross locomotor disabilities.

As more names appear in the register of handicapped persons more applications for adaptations to houses are also received. This has resulted in a pattern of sharply rising expenditure—in 1964/65 the figure was £172 in 1965/66 it was £424 and great care will be needed to keep within the budget figure of £900 for 1967/68. These adaptations to ameliorate conditions for the handicapped cover such works as providing ramps for those confined to wheelchairs, widening doors, fixing handrails and special fittings for bathing and toileting. It is felt that the cost of these adaptations should in general be borne by the District Councils so far as their property is concerned because the County Council, as the welfare authority, is faced with heavy commitments for necessary improvements to privately owned property which is rented to the severely disabled.

In September the Minister of Health, in conjunction with the Minister of Transport, revised the car badge scheme for disabled drivers. It was thought desirable, since the problem arising from ever increasing road traffic and consequent parking difficulties have a much more profound effect on the driver who is physically disabled, to give further publicity to the scheme. I am most grateful to the local newspapers for their help. There are now 59 drivers identified under this scheme in the County and it is likely that a further 10 badges will be issued as a result of the recent press notices.

Holidays for the Disabled

Once again the Committee was happy to assist financially and to co-operate with the Cumberland Council of Social Service in arranging holidays for disabled people. Their success owed much to members of voluntary organisations who gave their services or made donations.

It became evident that the lack of suitable accommodation was becoming a serious problem and many difficulties were overcome before a sufficient number of places was found at two holiday camps, one hotel and a boarding house—the last named providing accommodation for family holidays. Altogether 89 people took part, including relatives and escorts and, afterwards, the welfare officers were in no doubt about the beneficial effects of the holidays.

To illustrate the department's activities in the welfare of the andicapped, one of the social welfare officers (Mr. Ruddick) uotes the case of a woman of 47 who suffers from multiple lerosis and lives with her husband and two grown up children n a council house. She can walk unassisted, but with difficulty, n the home but outside activities are only possible in a wheel-hair. In association with the District Council a special driveway vas constructed which allows transport to pull up near the door n bad weather. She attends the craft and social club for the andicapped on two days a week and, along with her husband, oined the party of more seriously disabled for whom a holiday vas arranged at Prestatyn in September.

The client (Mrs. C.) comments as follows:—

"I was very prone to coughs and colds which have kept me bedfast for long periods. Now that the driveway has been built I escape the colds and the wetting and it has proved to be a great boon. After my family left for work I used to sit alone and was miserable. Now I am able to look forward to seeing my friends at the club on Mondays and Thursdays.

"At Prestatyn it was marvellous to be doing something all day long. All the entertainment was at hand and my husband waltzed me round the dance floor in my wheelchair. I shall never forget the holiday—it was my first since being confined to my wheelchair eleven years ago."

Blind and Partially Sighted Persons

The following table shows the age groups of blind and partially sighted persons registered on 31st December, 1967:—

Age Groups		Blind			Partially sighted		
		M.	F.	Total	M.	F.	Total
0—1	...	—	—	—	—	—	—
2—4	...	1	—	1	—	—	—
5—15	...	4	—	4	10	5	15
16—20	...	2	3	5	4	4	8
21—49	...	30	18	48	16	11	27
50—64	...	35	34	69	11	15	26
65 and over		122	246	368	46	54	100
TOTALS	...	194	301	495	87	89	176

The number of blind increased by twelve and the partially sighted by seven during the year, whereas in each of the preceding three years there had been a slight downward trend in the total numbers on the registers. New registrations amounted to sixty-six blind and forty partially sighted. Since nearly three-quarters of the blind and more than half of the partially sighted are over sixty-five years of age it is easily understandable that most of the removals from the register are because of death.

Because of the difficulty in recruiting qualified home teachers of the blind it was decided to engage a welfare assistant in the southern area of the county. Repeated advertising for a home teacher having failed to attract a single candidate, the total case-load normally covered by the two home teachers was carefully sifted so that those requiring social support involving a lesser degree of skill could be supervised in the main by the welfare assistant. This enables the home teacher to devote her time entirely to those blind and partially sighted in the community who could benefit by home tuition or whose case-work problems require the attention of a trained social worker.

Craft and social classes are held at thirteen centres throughout ıe county under the supervision of a home teacher and/or social elfare officer. Two classes for the partially sighted are held at e Maryport Educational Settlement at which tutors are provided y the local education authority—one for choral singing and the her for pottery. A craft class for the blind and the handicapped also held at one of the smaller residential Homes for the elderly Grisedale Croft, Alston).

Miss Shuttleworth the home teacher at Workington is arrang-ıg through the Foundation of the Blind in Auckland, New Zea-ınd, for the mutual exchange of tape recordings. She also tells ıe that the new talking book cassettes are greatly appreciated. ın improved model of play-back machine and cassette have been dopted by the British Talking Book Service for the Blind, the assette providing thirteen hours recording (the average book taking leven hours) and in addition the cassette is small enough to be osted in a letter box and it much less liable to damage in transit.

The Barrow, Furness and South Cumberland Society for the Blind continue to act as agents for the County Council in the rovision of welfare services in the southern part of the county. Craft classes are held weekly in the Baptist Church Rooms at Millom. Mr. D. Webb has replaced Miss Andrews as home eacher.

Workshops for the Blind

When the administration of the workshops for the blind was taken over from the voluntary organisation under a joint arrangement between the County Council and the Carlisle City Council at the end of 1962 sales of products had averaged about £14,500 during the preceding years. Since then the policy of the Joint Committee has been to modernise the workshops by the introduction of industrial techniques, to provide more satisfying employment to those working there by improving working conditions and to reduce the range of products by diverting labour into the more profitable lines. In general this has meant that the producion of many of the goods which have for many years been traditional in such workshops, has been abandoned in favour of products for which there is a greater demand.

One yardstick which could be applied to assess this policy lies in the value of products sold in relation to the numbers employed which is as follows:—

Year		Sales	Number of employees (including trainees)
1963	...	£18,967	30
1964	...	£24,023	33
1965	...	£30,219	37
1966	...	£34,368	32
1967	...	£35,693	33

Protracted negotiations between bodies representing employers and employees resulted in an arrangement which it is hoped will enable both management and employees to work together to increase efficiency and achieve maximum productivity. This agreement introduced a new wages structure which replaced the system of "augmentation" of wages by one under which all payments to workers were treated as wages and linked further wage movements to those effecting manual workers for local authorities.

In May an Inspector of the Ministry of Labour (Mr. K. F. winfen) visited the workshops and his report was considered by ne Joint Sub-Committee. His comments were directed on to :wo main channels:—

(a) The financial position of the workshops and

(b) internal re-organisation and structural re-arrangement to increase productivity and efficiency.

The production loss per worker compares favourably with the ational average for similar workshops but a careful investigation, articularly into overhead costs, was mounted into selling and istribution costs, establishment charges and the costs of admin-tration, to see if economies could be effected. The workshops how an encouraging increase in production over the years but nese tend to be outweighed by wage increases and result in a ett fall of trading profits. The market for goods becomes in-reasingly competitive. A delicate balance has therefore to be naintained regarding the selling price of products as it is con-idered more desirable to maintain full employment than to risk osing customers by pricing goods out of the market.

Careful analysis of the productivity of all departments re-ealed that the basket department had the highest manufacturing oss in the workshops. This again is a traditional craft which roduced goods for which there is a declining demand and the nspector's recommendation that it be gradually run down was oth expected and to some extent anticipated. The employees vill be absorbed after retraining into other departments of the vorkshops.

Mr. Swinfen's report made recommendations for structural e-arrangements within the workshops to increase working areas nd to simplify supervision by the removal of some internal par-tions. To provide more storage space and to minimise the hand-ng both of raw materials and finished products it was advised hat the loft over the main workshops be utilised for storage urposes. The cost of these alterations will be met in the main y the Ministry of Labour by way of a specific grant and the oint Committee propose to carry them out during 1968/69.

The Manager of the Workshops (Mr. Holt) submits the following report:—

"During 1967 the workshop has steadily expanded its main activities. The Basket Department was closed in December, but we will continue to stock and sell baskets made by Associated Workshops. This department became uneconomical to run due to the retirement and sickness of two of the basket makers. All remaining employees have been moved to other departments where they are being retrained in different occupations.

"There has been a steady increase in sales in all departments, and a highlight of the sales activities in the Brush-making Department was a large export order of tractor brushes to the Persian Gulf on behalf of one of our major customers.

"We would like to thank the local authorities, retailers and the general public for their continued support.

"We are currently making new chairs, three piece suites and offering a reconditioning and recovering service in all types of upholstery.

"In liaison with the Ministry of Labour we have continued to accept severely disabled sighted trainees, and have had success in training up to skilled standards. Our activities in this direction have mainly been in relation to those suffering from epilepsy or heart conditions because those disabilities make it most difficult for them to be placed in open employment.

"We have again had many visits both by individuals and organised parties, and wish to thank all concerned for their keen interest in our work".

I am quite convinced that the best "welfare" which can be made available to someone with a seriously disabling condition is the security of a wage packet which results from acceptable

employment. The aim of the workshop is to provide satisfying work under sheltered conditions in congenial surroundings. Important as this may be, the welfare of the employees goes beyond the provision of a paid job—it should permeate the working environment, the home and the family. I have been delighted at the happy atmosphere which prevails at the workshops, and the team spirit which is so evident. The relationships which have been built up auger well for the future—management, foremen, employees and trainees have worked together with enthusiasm under conditions of rapid change.

In the home situation, the home teachers of the blind and the social welfare officers lend their active support as, and when, necessary. Apart from the excellent canteen facilities, it is perhaps indicative of the community atmosphere to mention that a lively "Blind Welfare Club" meets in the former hostel every Tuesday evening for purely social purposes. This club is also attended by wives and friends of the employees, and by other blind or partially sighted people living in the locality. It is run by a committee of employees with such help as may be necessary from the Manager and his office staff. Staff parties and outings are regular features in their activities. My grateful thanks are due to the Joint Committee for their continuing support, and to the staff and employees for their loyalty.

The Manager gives freely of his spare time in talking to interested groups (Women's Institutes, Rotary Clubs, and many church organisations) about the sheltered work provision for the blind and severely disabled. I am sure that this form of publicity has great value in enlightening the public about our (and their) responsibilities to the handicapped. Many of the organisations follow up these talks by accepting an invitation to visit the workshops.

It has long been recognised that serious disabilities are frequently accompanied by other handicaps and accordingly the general health level of the employees is much below average. This is reflected in a high sickness rate and, unfortunately, in the loss of valuable workers through death at relatively early ages.

Blind Home Workers

The Council's Scheme for the Blind provides for the payment of allowances to augment the earnings of those blind who work in their own homes. Probably because of the wider range of facilities which are available at the Workshops for the Blind there has been a gradual decrease in the number of blind home workers and there are now only two in the County, both of whom could loosely be described as smallholders.

During the year new rates of augmentation were adopted providing for maximum augmentation of £7 5s. 0d. per week payable on a reducing scale until the home workers earnings reach £14 per week.

Sheltered Employment

Schemes made by local authorities under Section 3 of the Disabled Persons (Employment) Act 1958 provide for the sheltered employment and training for such employment not only for the blind and the partially sighted but also for the sighted disabled. These disabled but sighted people may be trained and employed in Workshops for the Blind only to an extent which is approved by the Minister of Labour and I am pleased that in our own Workshops for the Blind up to 12 sighted seriously disabled may be so employed.

For some time I have been concerned that the opportunity for training and subsequent employment of those disabled people whose ability to work is limited by their handicap appears to be inadequate in this area. Training through the Ministry of Labour's Industrial Rehabilitation Units is in short supply and geographically virtually impossible for Cumberland's disabled. The only sheltered workshops provided through the Ministry of Labour (a Remploy Factory at Cleator Moor) always has long lists of those awaiting employment under sheltered conditions. Lists of those handicapped persons in the County who were thought by the social welfare officers to be possible candidates for sheltered work were submitted to the Ministry of Labour during the year. After investigation by the Disablement Resettlement Officers it was confirmed that rather more than 50 men and women appeared suitable to undertake sheltered employment even within the catchment area of a single factory if it were located between Whitehaven and Workington.

With the help of the Ministry of Labour a meeting was arranged with representatives of the Ministry's Regional Office, the Local Employment Exchange and the Town and Country Planning Department of the County Council to consider the merits of various sites in West Cumberland for the possible development of a sheltered workshop by the local authority for the physically and mentally disabled in that area. Such a workshop if approved by the Ministry of Labour, would of course attract financial support from that Ministry not only in the capital provision but also

contributions towards the running costs by way of training and capitation grants for each approved worker. The project is included in the Authority's proposed Capital Development Programme for the year 1970/71 and will probably be located within a developing industrial estate at Lillyhall which is within easy reach of both Workington and Whitehaven.

Deaf and Hard of Hearing

Welfare services for the deaf continue to be provided by the arlisle Diocesan Association for the Deaf as agents for the uthority under its approved scheme. The Association operates roughout the Diocese of Carlisle covering the counties of Cum-erland and Westmorland, the Furness area of Lancashire, and ie County Boroughs of Barrow-in-Furness and Carlisle, each uthority contributing pro rata towards the expenses of the ssociation.

Social centres, where the profoundly deaf can organise their wn social communities, are provided at Barrow (for the Millom rea), at Carlisle (for North Cumberland), and at the authority's remises made available to the Association at Workington and Vhitehaven (for West Cumberland).

I am indebted to Mr. J. M. Barber, the organising secretary f the Diocesan Association for the following report:—

"A great deal is spoken today about "community care" and "The welfare of the community as a whole". It is important when applying this to those born deaf, and the deaf without speech that we think of them as individuals and also as a community, i.e. taking the isolation aspect of the individual, and the need for communal activities of the group because of this isolation. The Carlisle Diocesan Association for the Deaf as agents for Cumberland County Council is proud to say that it is able to carry out a comprehensive service for this group of people.

"Over the past year visits to and on behalf of the deaf have increased, and all manner of problems have been dealt with. Also in this past year, with the kind help of Cumberland County Council letting us have the use of the Flatt Walks Social Centre at Whitehaven we have been able to open a further social centre for the deaf in West Cumberland. This now brings the total number of centres available to five—Carlisle, Workington, Whitehaven, Kendal and Barrow.

"Recreational activities are provided at these centres, and a qualified welfare officer for the deaf is always present. In the friendly atmosphere which prevails these deaf people can come and relax; there is no strain, there is no fear of being misunderstood. They come along, talk to their friends, and have a quiet word with the welfare officer and explain their problems to him. These problems vary in size but to the person involved they are all of utmost concern, and each one is given careful attention and dealt with in a proper manner.

"Although everything is done to encourage the deaf to live a full life, and achieve as much independence as possible, there are still times when they need assistance. Most important perhaps is an interview with a doctor, solicitor, employer, or the Ministry of Transport Driving Examiner, when it is essential that they understand fully what is being said. In these cases a qualified interpreter who can explain in their own language everything that is being said, clearly and lucidly, and can **also** fully understand everything the deaf person has to say, is very necessary.

"Church Services are held every Sunday, and we are thankful to the Reverend N. Dixon of Whitehaven for celebrating Holy Communion on our behalf at Whitehaven, the Reverend Canon W. Bucks at Barrow, and Archdeacon Nurse at Carlisle.

"Over the past year the social recreational activities have ranged from bowls matches against hearing teams, weekly badminton classes, fell walks, climbing, football, bingo, whist, educational film shows, fancy dress parties through to outings to Edinburgh, Ayr, Blackpool, and a National Rally held at Tynemouth.

"We hope in the coming year to provide an even wider range of activities for the deaf."

The Club for the Hard of Hearing continues to meet monthly on a Friday evening at the Council's Clinic at Wigton. There

as been no significant change in membership during the year nd a purely social programme is arranged by the senior social elfare officer to include speakers and demonstrations on topics f general interest. There seems to be a limited scope for this ctivity as the members are well integrated in the community nd have many other interests.

Day Centres, Luncheon Clubs, Meals on Wheels

The interweaving of effort between statutory and voluntary agencies and the versatility of arrangements which emerge to meet differing local requirements make it quite impossible to report in detail on these aspects of care for the elderly. The dividing lines between these three main forms of support tend to be blurred by their similarities and for brevity I would like to make the following general observations.

Day Centres

Day care for the elderly is provided at many of the residential Homes. This makes a valuable contribution to the spectrum of total care within the community, particularly in relieving the difficulties of those elderly who may be awaiting a place in a welfare Home. Apart from the dietetic value of the meals supplied, general care by way of bathing, nail cutting and chiropody can be afforded, and the day visitor can enjoy the company and companionship of the residents. In many cases day care for as little as one or two days a week can so influence the individual situation that the need for full residential care assumes less urgency, and may even no longer be considered necessary.

The need for day care for the elderly is determined by those in the best position to assess the medical/social needs of those old people "At Risk" in the community, namely the family care team of general practitioner, domiciliary nursing staff, and social welfare officers. A much more generous provision of this form of service would help in reducing the waiting list for admission to welfare Homes. Two main factors operate against the further development of day care in its present form. Firstly there must be control over the number of day visitors in relation to residents in a welfare Home, if the character and atmosphere of the Home is to be preserved. The Ministry's suggestion is that day visitors should not exceed 30 per cent of the number of residents, and with this limit I cannot disagree. Of much greater significance

are the difficulties associated with transporting these elderly between their homes and the Day Centre. Many of those attending cannot travel in ordinary cars, and in consequence an increasing burden falls on the strained resources of the Ambulance Service.

Looking to the future I feel that a study might be undertaken to assess the viability of building and equipping separate Centres for day care. More detailed investigation may well reveal that day care on a more generous scale would effectively reduce the demand for full residential care.

Luncheon Clubs

The primary purpose of these Clubs is to give the elderly person living at home the opportunity of a well balanced meal at minimum cost but a "hidden bonus" obviously accrues in that they enjoy the social intercourse and companionship which is such a happy feature of these enterprises. Three additional Clubs have been opened during the year (at Cockermouth, Aspatria, and Cleator Moor) making a total of twelve throughout the county. Five are run by Old People's Welfare Committees, four by the Women's Royal Voluntary Service, and three operate in welfare Homes. In total they provided just over 13,000 lunches in 1967. Once again the variety of arrangements for inaugurating, organising and staffing these Clubs seems to have no limit. Of particular interest are those Clubs which are so ably conducted by senior school children with minimal supervision from their teachers—truly a commendable exercise in "civics".

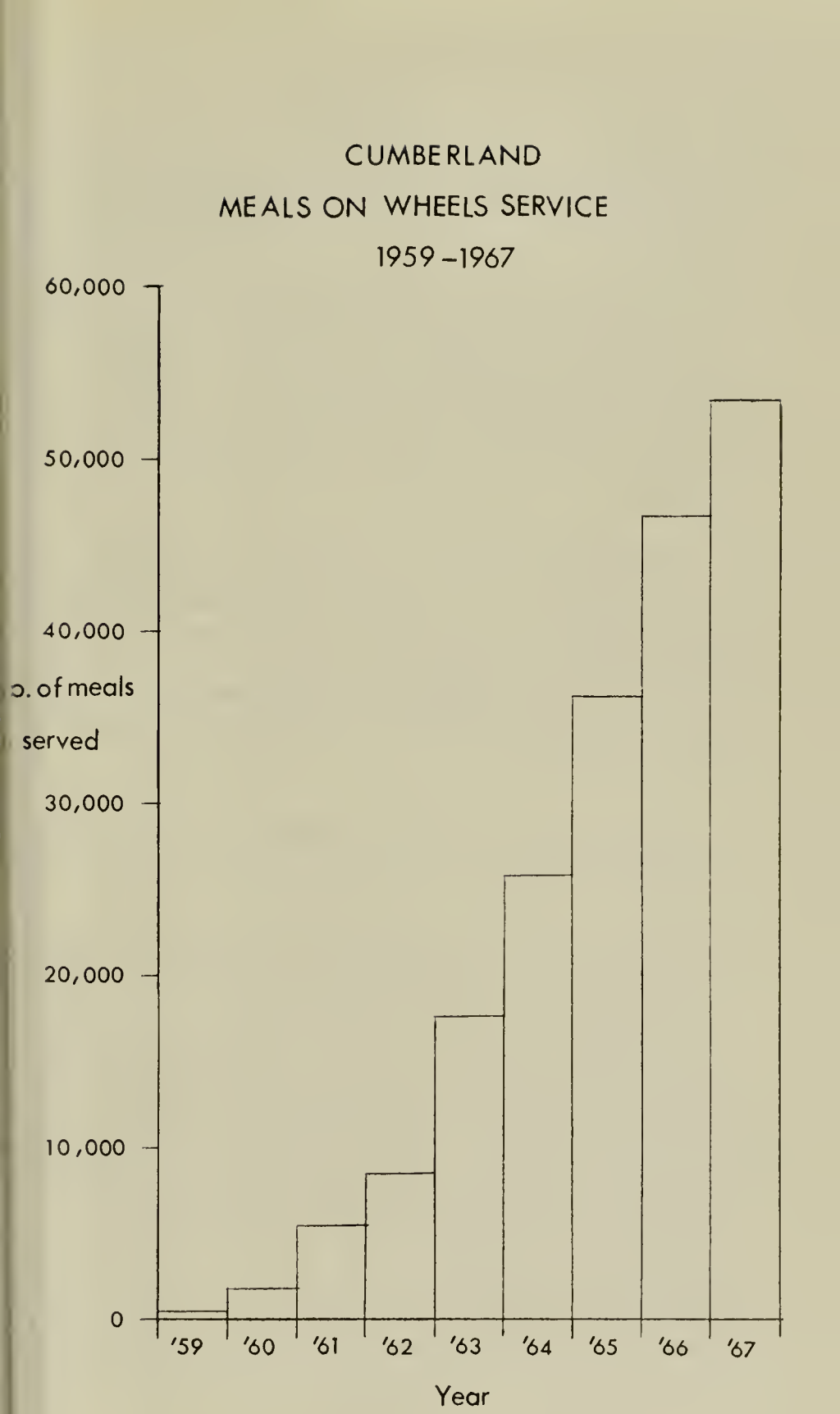
Meals on Wheels

The authority continues to look to the Women's Royal Voluntary Service for its sterling work in providing the meals on wheels service. Meals are supplied to the homes of the housebound or those unable to attend a Luncheon Club, only on the basis of need as assessed by the family health care

team. The calls on this service continue to increase becau there is an ascertained need to extend the service to mo and more elderly people living at home and to provide mea more frequently—particularly at weekends. Each succeedir year establishes a record figure—in 1967 it was 53,296, havir leapt to that level from less than 2,000 in 1960.

While the time and effort so generously given by mem bers of the Women's Royal Voluntary Service is beyond prais and ever increasing demands on their service are met withou complaint, it is clear there must be a limit to their resources Considerable thought is being given to the best way in whicl the situation can be improved when such a limit is reache so that the full value of the efforts of the Women's Roya Voluntary Service can be retained. So far as local authority expenditure is concerned, this is a permissive service and up to now the Council has been able to accept the rising costs. During 1967, however, because of the overall pressures on rate borne expenditure it became necessary to increase the charge for the midday meal from 1/- to 1/3. Rate borne expenditure on Meals on Wheels and on Lunch Clubs having increased thirtyfold in the space of five years, the only alternative to lifting the charge to the recipient, in view of rising costs of production of the meals, would have been a cut back in the number already being supplied.

Over the years, the Meals on Wheels service has acquired five vans to assist deliveries in this very rural area. Three have been given by Round Tables (of Workington, Maryport and Cockermouth), one by a private benefactor, and one was provided from rate funds. In 1967 a sixth van was presented to the Women's Royal Voluntary Service by the Rotary Club of Egremont—an admirable gesture on the part of one voluntary organisation straining its efforts specifically to help another in recognition of its services to the community.


CUMBERLAND
MEALS ON WHEELS SERVICE
1959 – 1967
60,000
50,000
40,000
o. of meals
served
30,000
20,000
10,000
0
'59
'60
'61
'62
'63
'64
'65
'66
'67
Year

TRAINING

Staff meetings at regular intervals which have now become an established routine throughout the department (at approximately quarterly intervals) have continued throughout the year. The officers from each discipline come together on a county wide basis to discuss developments, to consider new projects, and generally to pool experiences. The matrons of residential Homes and the social welfare officers continued their conferences on this basis, but both groups invite representatives of other sections of the department and the voluntary services to join them in their discussions to co-ordinate effort and to maintain effective communications.

The policy of seconding residential care staff to the training courses organised by the National Old People's Welfare Council has continued within the restrictions imposed by financial considerations and the availability of places on the courses. During 1967 one matron attended the full fourteen week course, and three were seconded to refresher or special emphasis courses of one week's duration.

In addition to these routine training procedures, there have been interesting and I feel sure profitable excursions into the field of training which should be recorded:—

(a) Arising from a suggestion raised at a meeting of matrons, it was decided to organise a local "in-service" course of training mainly for attendants in welfare Homes for the elderly. This was partly stimulated by the fact that suitable courses were not available within reasonable travelling distance, but also because many more attendants could be given basic training at much less cost if a course were organised within the Authority's own resources. The programme was spread over a seven week period between Easter and Whitsuntide on a one day release basis each week. Even this presented many problems in the re-arrangement of duty rotas—especially in the smaller Homes which carry only a few members of staff. The response and enthusiasm which was shown throughout

the course more than justified the effort. Altogether twenty-five attendants (including two from the City of Carlisle), seven domestics, an assistant matron, a trainee, and the warden of a supported independency scheme attended the course at Cockermouth.

The subjects covered included:—

1. The history and background of local authority care.
2. Attitudes encountered in the family and by the individual to residential care.
3. Nursing techniques for the elderly.
4. Diet for the elderly. Care of hair, skin, nails and teeth.
5. Common ailments of old age.
6. Recognition of early psychiatric breakdown—changes in behaviour patterns of the elderly.
7. Orthopaedic and physical handicaps.
8. Foot care for the elderly.
9. Fire preventive procedures.
10. Voluntary services and the involvement of the community in Welfare Homes.
11. Encouraging independence activities within the Home.

Practical demonstrations were arranged on bathing on toileting, sinple remedial exercises and the use of appliances. Various types of fire appliances—their function, maintenance and position were also demonstrated. A day geriatric hospital and a craft class for handicapped persons were visited.

To all those members of my staff, to Dr. Kaminski, Consultant in Geriatrics and to Dr. T. Fletcher, who discussed the general medical practitioner's aspect so ably, I must tender my

sincere appreciation for their contributions which resulted in such a successful venture into a new field of training. My special thanks must be accorded to Miss Zena Williams, Regional Welfare Officer, for her chairmanship at the final session. Miss Williams will shortly be moving to another region and, at this stage, I would like to place on record my gratitude for the unstinting help, guidance and support in all welfare matters which she along with the Principal Regional Officer, Mr. Ellerington have so generously given at all times.

One of the attendants who attended the course (Mrs. Joyce of The Towers) says:—

> "I am sure that all those who attended gained a great deal from the lectures, demonstrations and discussions which covered so many of the duties of the attendant in a welfare home for the elderly. The course reminded us of the importance of our work and gave us the opportunity to meet together to compare experiences. We now feel more able to put the theory into practice."

(b) The Chief Constable enquired in March if arrangements could be made to include within the training programme for police cadets a period of secondment to the Health and Welfare Department "with a view to broadening their knowledge and deepening their understanding of the society which it will eventually be their duty to serve". After many discussions on the detailed arrangements, a programme was agreed and the first cadet completed a four week secondment period in July. From the police aspect the aim was to give practical experience to the cadet in the field of human relationships, and to this end it was thought important that he (or she) should not be regarded as an observer, but that every opportunity would be created for active participation in work involving personal contact with the handicapped, inadequate, and elderly, in the community. The training period included a full week at a residential Home for the elderly, three days at an Ambulance Station, two days at a residential hostel and training centre for mentally handicapped children, and

visits with welfare officers and nurses to craft classes, social clubs for the handicapped, and in selected cases in visiting those who were receiving some form of social support in their own homes.

The first attempt was thought to be successful in laying down the outline of what will probably become a regular feature of police cadet training. In the long term this can only result in improved relationships and communication between the police, this department, and the public we serve.

I am grateful that there is such a large fund of voluntary effort which is directed mainly towards helping the elderly in the community. These volunteers have associations in the main with three organisations—the Welfare Secretaries and the Old People's Friends of the Women's Institutes, the village representatives of the Women's Royal Voluntary Service, and the local secretaries and helpers of the Old People's Welfare Committees. In many instances the same voluntary worker fills a similar office with more than one organisation.

It was thought to be important, especially with the development of the family health care team, that an effort should be made to clarify any doubts which may exist as to the simplest and most effective method by which the voluntary worker could marshal the support of the appropriate statutory service when faced with a local problem—especially in an emergency. A pamphlet was drafted which was intended to serve as a guide to all the areas in which help might possibly be required. This was quickly rejected, mainly on the grounds that to be useful in isolation such a document must necessarily be very comprehensive and would require constant revision to keep it up to date.

A brief "Note for the guidance of voluntary workers" was prepared and, on the premise that the most effective channel of communication is by personal contact, the voluntary workers from relatively small areas were invited to meet together. The stencilled notes for guidance were distributed and formed

the basis of discussion and questions. Fifteen meetings were held and all were attended by the area nursing officer, the appropriate social welfare officer, and all the nurses from the area represented at the meeting in addition to myself or my deputy. It was thought to be of paramount importance that the voluntary worker should have speedy access to the local authorities services, and that the person of first contact to mobilise any section of the department's activities should be the community nurse (either health visitor or district nurse) serving the locality. This was clearly defined in every single village, and the meetings provided the opportunity for the voluntary worker to meet the local authorities representative to whom she could look for help and/or guidance. The nurse would, of course, either call in the appropriate agency or advise the voluntary worker on lines of communication. The close association which exists with the general practitioner and hospital services through the attachment of nurses to family doctor groups of course simplifies the enlisting of aid from these sources.

(d) Again as a result of discussions at one of the matrons' meetings it was decided to mount short courses for cooks at the residential Homes for the elderly, and for others concerned with catering for the dietary needs of this age group. With the helpful co-operation of the catering departments at the Workington College of Further Education, and the Carlisle Technical College, one day courses were held at each centre. The subjects covered in discussion and demonstration included nutritional requirements, personal and kitchen hygiene, stock keeping and cost control, menus and the presentation of food. Of the forty-eight attending these short courses, ten were matrons, and fifteen were cooks from our own welfare Homes, but I was very pleased that seventeen voluntary workers from the Luncheon Clubs run by the Women's Royal Voluntary Service and Old People's Welfare Committee were able to join the courses.

MENTAL HEALTH

MENTAL HEALTH

In spite of the fact that there has been no major development the services provided during 1967. it is fair to state, that it is been both a productive and a progressive year. The theme the department's policy in mental health, as in other spheres, is been the furtherance of a closer co-ordination and co-operaon between the three partners of the National Health Service. his coupled with the system of area administration has meant at the Cumbrian in spite of his relative remoteness, has been well served and cared for as the present resources will permit.

One development, however, was the introduction of experiental pilot schemes in each of the three administrative areas. ne of the aims of these pilot schemes was to assess the physical d mental disabilities of the over seventies in the community that more accurate planning for preventative medicine can made. The National Health Service Executive Council, was proached and requested to forward the names and addresses of e over seventies in the selected areas. A percentage of these ere visited in their own homes by part-time relief nursing staff. o physical examination was made. A questionnaire was devised such a form as to provide quick answers, and an on the spot inion as to whether or not the conditions were satisfactory. The llowing is an extract of that questionnaire relating to the mental alth aspect of the investigation:—

1. Reasonably alert.

2. Generally happy and contented.

3. Evidence of confusion.
   depression.

   satisfactory/unsatisfactory.

Two hundred and six persons over the age of seventy were sited, and the results indicated that about 4 per cent of the mmunity elderly are in need of some form of mental health re. None of the people interviewed, however, required hospital lmission.

As a result of the survey it has now been decided that in future a domiciliary visit be made to all persons in the county on or about their seventy-fifth birthday. In this way it will be possible to screen all the elderly within the administrative county in such a manner as to avoid a sudden burden on any section of the Health Services.

The first social worker attachment to a group practice of medical practitioners commenced at Seascale towards the latter part of the year. Although it is still very much in embryo the indications are that the best method of preventive social medicine is orientated around the general practitioner. Although only one attachment of a social welfare officer has taken place to date, it is true to state that throughout the county the bond between social worker and the general practitioner has been greatly developed during 1967. Most General Practitioners are now visited weekly in their surgeries by the social worker. This is further emphasised by a markedly closer link between the social worker and the health visitor.

An important factor in this bonding of our tripartite National Health Service is the experience of the effectiveness of the social worker within the team. This factor is now being appreciated by the "leaders of the teams".

The following table is an extract of some of the statistical ormation required by the Ministry of Health in a return of the ar's happenings:—

se load at year end	1961	1962	1963	1964	1965	1966	1967
Mentally ill and psychopathic	115	250	292	328	396	447	452
Subnormal and severely sub-normal	351	359	391	437	449	511	497
TAL	446	609	683	765	845	958	949
On training centre registers	71	86	95	119	135	162	168
Awaiting admission to training centres	42	46	42	45	39	3	10
In local health authority residential care	18	21	16	33	25	38	61
n hospital waiting lists (subnormals)							
Urgent cases	—	1	1	4	1	—	—
Others	—	39	46	31	20	13	12
ew cases referred—							
Mentally ill and psychopathic	194	235	211	230	223	202	184
Subnormal and severely sub-normal	35	71	42	86	62	70	40
OTAL	229	306	253	316	285	272	224

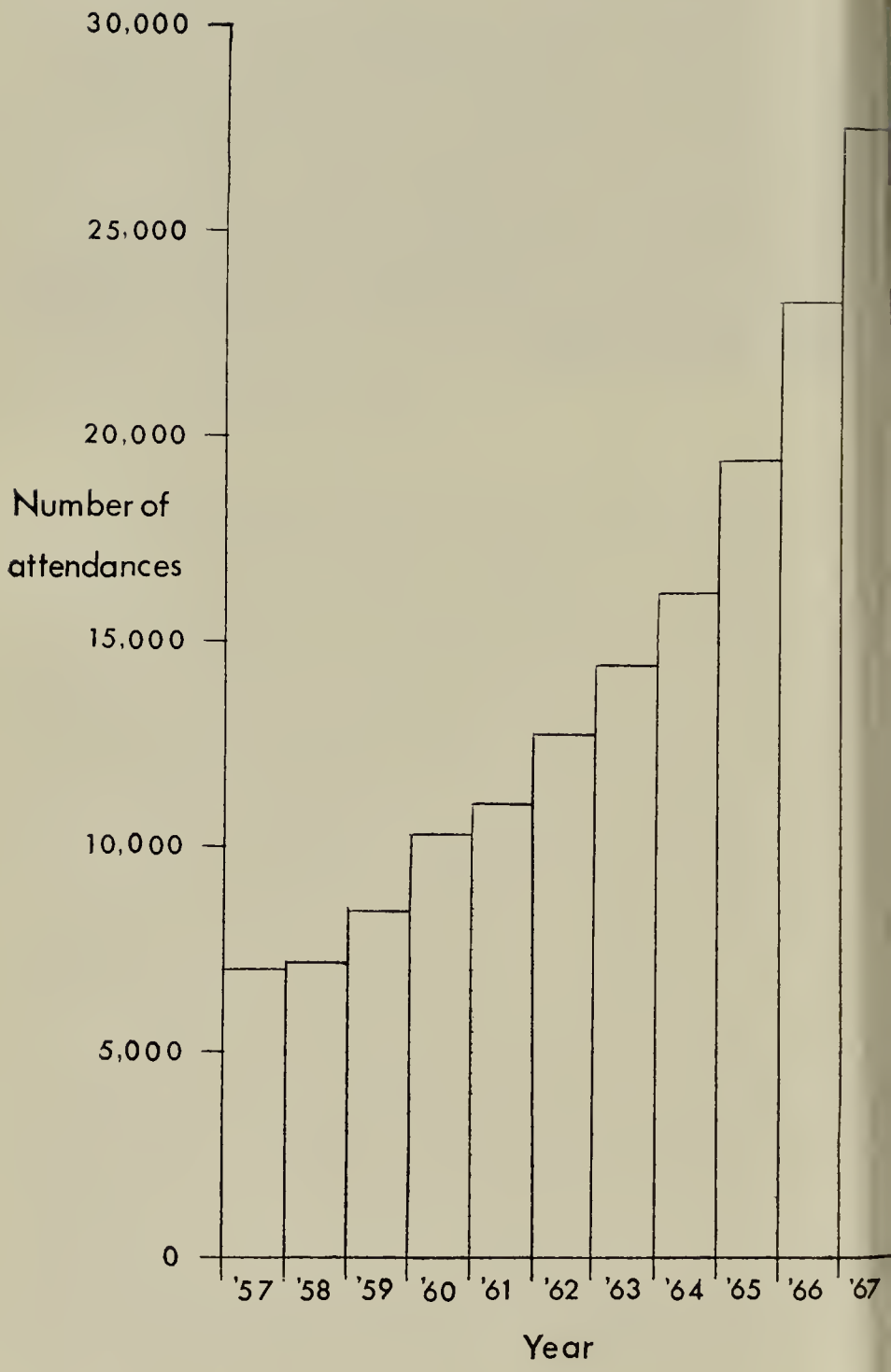
The gradual increase in the number of patients under local ealth authority care in their own homes reached a peak in 1966. his is partly due to the fact that it is now estimated that all ubnormal and severely subnormal patients within the county are nown to the department. The slight decrease of 2.7 per cent n numbers of subnormals and severely subnormals is not sign- icant, and is attributed to hospital admissions during the year. n previous years a similar number have for various reasons had heir names removed from the supervision list, but this has been oncealed by the number of persons found to be subnormal or everely subnormal within the administrative county. Another eason for the slight drop during 1967 in the number of patients n their own homes under local authority care, is the awareness n the part of the hospital consultant psychiatrists of the pressures nder which the social welfare officers labour. The social welfare fficer staffing ratio in Cumberland is not only realistic, but it is lso above national average at .08 per thousand of population. On the other hand, however, during 1967 twenty five per cent f the staff were undergoing professional training. This is without

doubt a reflection of the enlightened approach of my Committee and is an investment for the future, but it has restricted the performance of the service during 1967. Mental health duties form approximately half of the social welfare officers function, and in spite of their proven value it is considered that they have reached their caseload saturation point. This problem has been more acute in the Western and Southern areas of the county, and is reflected in the number of persons referred from the psychiatric unit of the West Cumberland Hospital and its associated clinics during 1967. This was only seventy-five as compared with a hundred and twenty-seven during 1966. In spite of this, however, these figures still compare very favourably with those referred from Garlands Hospital and its associated clinics, i.e.—eight during 1967—and seven during 1966.

In previous reports the alternative method of compulsory admission of mentally disturbed patients to hospital have been commented upon. The Mental Health Act 1959, Section 25, laid down the normal procedure for the compulsory admission for a period of observation. This demands that two medical recommendations be provided. One by a practitioner who has previous acquaintance with the patient if possible, and the other by a medical practitioner approved by the local health authority as having special experience in the diagnosis or treatment of mental disorders. These medical recommendations may only be submitted by practitioners who have personally examined the patient together or at an interval of not more than seven days. Section 29 of that Act laid down an emergency procedure for compulsory admission to a hospital for a more limited period of observation. This emergency procedure is founded on one single medical recommendation and is used where the time factor is vital, and a delay in obtaining a further recommendation from an approved practitioner is considered to create an unnecessary risk. During 1967, of the compulsory admissions notified to me in North Cumberland 84.7 per cent were initially for periods of observation (Section 29 or Section 25). Of these admissions 77.1 per cent were admitted as emergencies under Section 29. Only twenty-five per cent, however, of these emergency admissions did not require further compulsory procedures to have the patients detained in hospital.

Although there has been an increase in the usage of Section 29 emergency procedures during 1967, this is not thought to be excessively high. It must be remembered that a proportion of these admissions were known to the consultants at the receiving hospitals prior to their emergency need. Because of the wide catchment area and the restricted number of approved medical practitioners, it has neither been possible nor practical to obtain the second medical recommendation without delaying the patients admission thus creating a degree of risk. The very high percentage of subsequent compulsory powers required to detain the patients justifies the action taken.

TRAINING CENTRE ATTENDANCES



JUNIOR TRAINING CENTRES

Due to the foresight of my Committee, Cumberland is well served by Junior Training Centres, providing purpose built facilities for 0.52 per thousand of the population. This has meant that no children, who require such training have had to wait for admission to a Centre. In spite of the remoteness of many parts of the county, the two Centres at Wigton and Hensingham are serving the need more than adequately. This is made possible by the use of the hostel for junior subnormals at Orton Park. At this hostel twenty-two subnormal children can be accommodated from Monday until Friday of each week, and travel to the Wigton Centre.

As can be seen by the preceding histogram total attendances at Training Centres increased by 4,264 or 18.3 per cent over those for the year 1966:—

Training Centres—Number on Registers—TEN YEARS TO 1967

Year	Under 16 years	16 years and over	Total
1958	32	14	46
1959	43	17	60
1960	49	21	70
1961	51	20	71
1962	61	25	86
1963	59	36	95
1964	73	44	117
1965	77	58	135
1966	99	63	162
1967	110	70	180

Attendance at the Hensingham Junior Training Centre which opened in April, 1966, increased during the year by 33.8 per cent, as compared with 1966. At the 31st December, 1967, sixty-four trainees were on the register. As this purpose built centre was designed for seventy-five trainees, the needs in the West Cumberland area will be met for some years without further development.

A valuable feature of this Centre is that it provides for separat nursery, junior, intermediate and senior groups of mentally handi capped children. A special care unit is also provided for childre who suffer from severe or multiple disabilities. An active Parent Association assists this Centre in many ways, and in addition t financing a summer outing to Ravenglass has given £60 to pur chase specially designed bus seats. A further special bus seat wa donated by the makers Messrs. Myers and Bowman Limited Distington. These seats enable special care unit children to b transported safely to and from the centre.

The services provided are greatly appreciated by the parents. Recently one parent wrote of the Hensingham Centre.

> "I was struck by the general atmosphere of the Training Centre which was bright, modern and cheerful, which had obviously been designed to cater for all types of handicapped children.
>
> "In these times when considerable sums of public money are, quite rightly spent on better education for the majority of children, it gives us (and I am sure speaking for all the parents) a sense of great appreciation that your County Council is prepared to build and organise these facilities for the less fortunate handicapped children who reside in the county".

I should also like to record that support for this Centre has been forthcoming from other sections of the community in the Whitehaven area, including a donation of £50 in September, 1967, from the Ladies' Circle. With this money tricycles, walking aids and educational toys were purchased.

The Wigton Junior Training Centre attendances increased by 6.5 per cent during 1967, as compared with the previous year. This small increase is what one would expect in a more established centre. At the 31st December, 1967, thirty-five trainees were on the register at the Wigton Centre. This leaves four vacancies which should meet the need in this area for the next four years. Three out of four of the staff at this centre are now recognised as qualified teachers of the mentally subnormal.

One child from the county attends the City of Carlisle Junior Training Centre at Kingstown. It is hoped that when the new purpose-built centre at Kingstown is opened during 1968 that facilities for mentally subnormal children in the area surrounding Carlisle will continue to be made available at that centre. This is at present being discussed with the City of Carlisle representatives.

SPECIAL CARE UNITS

A small number of very severely handicapped children who are so severely disabled that they are unable to profit from the type of training available at the Junior Training Centres are provided for in two special care units in the county. One at the Junior Training Centre at Hensingham where ten children can be cared for, the other at Orton Park Hostel where six children can be admitted.

Because of the demand for this service in West Cumberland a rota system is operated at Hensingham. This ensures that the known severely disabled children in the area each attend for part of the week. The demands on staff are heavy, but the value to the parents more than compensate for their efforts. The vast area served by this unit is an important factor. As previously stated thanks to the efforts of the Parents' Association and Messrs. Myers and Bowman Limited, Distington, four bus seats have been specially made to enable a proportion of these children to be conveyed safely from their homes to the unit by the coach which brings the other trainees to the Hensingham Junior Training Centre.

At Orton Park, four children from Penrith, Wigton and Curthwaite are brought to the unit every Tuesday. The transport is provided by the Ambulance Service. As these children are very severely disabled being non-ambulant, doubly incontinent, and require to be fed, a trained nurse and an assistant, staff this unit. Although opened only on one day of each week this short respite is very much welcomed by the parents, and helps them to face the rest of the week.

ADULT TRAINING CENTRE

The demand for places at Distington Adult Training Centre continues to grow. During the year a further five trainees have been admitted making a total on the register at the 31st December, 1967, of sixty-five, consisting of thirty-nine males and twenty-six females. This has resulted in a 9.6 per cent attendance increase as compared with 1966. A further five male trainees are awaiting admission, and during the year, five trainees at Hensingham and Wigton Junior Training Centres, will attain the age of sixteen, when they should be transferred to Distington Adult Training Centre. Unfortunately, all five are males and it is in this section, that the accommodation is most cramped. The prospect of the planned extension of this centre because of the financial climate is no nearer. Recently it has been necessary to delay the commencement of the building of this extension to the latter part of 1968/69.

In spite of the fact that the Workshop facilities at Distington are only designed to cater for fifty trainees, progress in the training of semi-industrial processes has continued. This consisted of making coat hangers and builders' wall ties from galvanised wire, the fabrication and creosoting of garden interwoven fencing, the packaging of small items of hospital equipment in readiness for their sterilisation, the manufacture of concrete slabs, and the printing of office stationery. During the year the sale of these goods and services earned an income for the centre of £2,044. 3s. 11d.

Each trainee has been assessed in his or her ability to perform these tasks, and although no-one from the centre has so far been placed in open industry, it is thought that four males and three females are now approaching this standard. The high level of unemployment in the West Cumberland area is, however, an unfavourable factor.

A number of social activities have also been arranged for the trainees. The highlight of these was an outing to Blackpool in September. The cost of this was met by the Parents' Association which is very active. The Blackpool Illuminations was one of the attractions, but the trainees also saw the film "The Sound of Music".

In the Northern and Eastern part of the county, the City of Carlisle Health and Welfare Department continues to make the Adult Training Centre at Kingstown available for five county trainees. A new purpose-built centre is nearing completion at Kingstown, and it is hoped that agreement will be reached to enable trainees from the county areas surrounding Carlisle to attend this centre in greater numbers. Until a hostel for subnormals is opened within travelling distance of the Kingstown Adult Training Centre the numbers, however, will continue to be limited. It is expected that only a further two county trainees will be available for admission during 1968. At present I am unable to say when a hostel for subnormals will be built in the Carlisle area, but it is thought that it will not be within the next three year period.

HOSTEL ACCOMMODATION

a) **For Subnormals**

The Orton Park Hostel for mentally subnormal children has had a most successful year. This hostel which was opened in 1959 to enable the children from remote areas not served on a day basis by Junior Training Centres, to be accommodated from Monday mornings until Friday evenings during term to enable them to attend the Wigton Junior Training Centre. The hostel provides places for twenty-two children. At the beginning of 1967 only sixteen children were regularly accommodated, but this has now been increased to twenty children. These children come from all over Cumberland, from Millom in the South to Gilsland in the North. A trend during the year has been for a much younger age group to be cared for. During 1966 only 6 per cent were aged six or under, and 37 per cent were aged ten or under, now however, twenty per cent of the residents are aged six or under, and fifty-eight per cent are aged ten or under.

The future policy for this type of accommodation is that during the periods 1971 to 1976 Orton Park will be replaced by smaller "family unit" type homes.

b) **For the Mentally Ill.**

The purpose built unit at Whitehaven called "Fairview" was opened on the 8th February, 1966. It has accommodation for seventeen post-psychotic patients. When originally proposed there were few similar hostels in the country and it was therefore extremely difficult to predict what the demand would be in Cumberland. The kitchen, dining room and lounge accommodation was designed for thirty residents so that the hostel could be easily adapted for that number should the need justify such action.

The aim of this type of hostel is to provide:—

1. A stepping stone to temporarily accommodate residents recovering from a mental illness involving hospitalisation, in a secure yet unstructured environment, where they can adjust and respond to the needs and demands of the community, before returning to that community.

2. To provide temporary accommodation at times of social crisis for persons in the community, known to the local authorities, who have suffered from a mental illness, or who are suffering from a mental illness which does not warrant hospitalisation.

As was planned the hostel opened gradually, and by the 1st January, 1967, it was accommodating fourteen residents having discharged a further nine residents to the community, and six residents back to hospital. Unfortunately, in June, 1967, the warden, Mrs. Cowham left the service when her husband obtained employment in another area. Because of this, and the fact that it has proved difficult to find a suitable, trained warden, I found it necessary to restrict the number of admissions for the remainder of the year. I am pleased to say that interviews are to be held on the 7th March, 1968, and from applications received it is likely that a warden will be appointed.

In spite of this setback "Fairview" has had fourteen new admissions during 1967. Of these, three were admitted from West Cumberland Hospital, five from Garlands Hospital, and six from the community. A further five re-admissions occurred during 1967, one from West Cumberland Hospital, two from home, and two from seasonal hotel employment. Another feature requiring constant review is the fact that the average duration of stay per resident has increased from forty-five days per resident in 1966 to a hundred and eight days in 1967. This, however, is not alarming in itself, but a difficult problem is a group of five residents who have been in "Fairview" since 1966, and there is at present little prospect of their being settled in the community in the foreseeable future.

During the year twelve residents obtained employment. Of these six found employment of their own initiative, and six as the result of the warden's efforts. This is considered to be satisfactory in view of the very heavy incidence of unemployment in the West Cumberland area, and demonstrates one respect in which the hostel has proved highly successful.

Twenty-four residents were discharged during 1967. Five eturned to hospital, nine to relatives or their own homes, five to esidential employment, one to lodgings, one to get married, one o return to her husband in Ghana, and two absconded.

ischarges	Male	Female	Total	Average stay—Days
eturned to hospital	3	2	5	51
o residential employment	3	2	5	98
o home or lodgings	7	5	12	75
bsconded	2		2	35
	15	9	24	65
emaining in residence 31st December, 1967	5	4	9	285

There has not unnaturally been some anxiety about the 50% verage occupancy of the hostel since its opening. Several factors ontribute to this I feel, among them the need for all concerned to earn how best to use such a hostel, and also the staffing set-back ssociated with the departure of the warden. However, the onfident hope of recruiting in the near future a new warden ualified and experienced in mental nursing; together with a lightly improved medical staffing situation at the psychiatry de- artment at West Cumberland Hospital giving promise of fuller nd better use of the hostel in the future. It should also be mphasised that the achievements to date despite some difficulties ave been considerable and very great benefit has flowed to the esidents who have used the hostel. I have no doubt as to its uccess.

It is also gratifying to see how wonderful the local residents t Bransty have supported the hostel in many ways after initial nderstandable misgivings about its situation in their midst.

During the interegnum of wardens Mrs. Hinde, acting warden, as done a wonderful job under difficulties and with my thanks o her go good wishes in connection with a new post to which he is moving shortly.

AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness ..... or expectant or nursing mothers from places in their area to places in or outside their area."

"IN-HOSPITAL TRAINING OF AMBULANCE PERSONNEL"

COUNTY AMBULANCE SERVICE

Mr. F. M. Smith, F.I.A.O., County Ambulance Officer, reports as follows:—

This year has seen a further increase in the work of this Service. The number of patients carried has increased from 105,585 to 118,367 (12%), while the mileage has increased from 1,116,733 to 1,192,339 (nearly 7%). It is pleasing to report that the increase in mileage has been less than the increase in patients and is no doubt partly due to increased skill in deployment of vehicles and men by means of radio control, and also to the efforts put into the pre-planning and grouping of out patient journeys by both the hospital and ambulance service staff.

The increase in mileage is due, in the main, to the increasing number of out of county journeys, the more frequent conveyance of geriatric patients, and the fact that most of the Millom patients are now referred to the West Cumberland Hospital, Hensingham, instead of the Barrow-in-Furness hospitals.

The mileage for out of county journeys, most of which are to the Newcastle area, is now approaching 200,000 miles per year and, although most are by Hospital Car Service, ambulances and dual purpose vehicles are used fairly often. If the average cost per mile is put at only 1/- the total cost of these abnormally long journeys is running at £10,000 per year. This is the price of being in an area remote from the specialist treatment centres.

About 20% of the journeys were to the Ministry of Pensions Limb Fitting Centre and, in view of not only the cost but the length of these journeys, representations were made to the Ministry of Health for a clinic to be established in Cumberland. There is no likelihood of this being provided in the immediate future but it is hoped temporary facilities may be provided in the early 1970s.

In contrast to the increase in mileage, it is noted that the number of call-outs to road accidents during the second half of the year shows a significant decrease over the first half, which is contrary to what occurred last year when the second half of the year showed a slight increase.

All home accidents to which ambulances are called out ar reported to the Area Medical Officer concerned for investigation In 35 weeks 180 such accidents were reported of which 44% (82 were falls in the home; followed by overdoses 22% (39) and scald and burns 12% (22). The remainder were of a varying nature.

During the year there were 5 births in ambulances. Tha they were dealt with satisfactorily underlines the value of trainin the staff in emergency midwifery.

It was necessary to arrange one helicopter journey to conve a patient, seriously injured in a road accident, from West Cum berland Hospital, Hensingham, to Newcastle General Hospital.

On 27th March a serious accident occurred on the Westmor land-North Riding border near Stainforth, when a bus full o young people returning to Glasgow from the south of Englan caught fire. Major Accident procedure was put into operation acting as agents of Westmorland County Ambulance Service vehicles from all neighbouring authorities being deployed and al casualties (none of which were fatal) were rapidly conveyed fro the scene to various hospitals.

In April a Major Accident Exercise "Border Incident" wa held at the Longtown railway siding and all services were involved The purpose of the exercise was to test:—

(1) the emergency scheme and the liaison between the service involved;

(2) the communications system;

(3) the Accident Hospital in dealing with a large number o casualties.

There were 99 casualties provided and made up by the Civi Defence Officer and his staff, who also provided refreshments.

From the ambulance viewpoint the exercise was a success, al patients being conveyed from the site in 90 minutes. The emer gency scheme, revised in the light of the theoretical exercise hel previously, stood up well to the test but some minor modification were shown to be necessary.

evelopments

As was indicated last year a possible further demand on the mbulance service might be expected as a result of health centre nd group practice development.

Transport is now being provided to take patients to the roup practice in Millom and has given very few problems. In ct, an unexpected bonus has been some slight reduction in the umbers of referrals of patients to hospital. Minor casualty work nd plaster checks for fracture cases, which were formerly taken o hospital, are now being carried out in the surgery.

The general practitioners in the Seascale area provided radio ansmitter/receiver sets in their own cars as well as a set at the nedical centre and these operate on the ambulance service fre- uency. There have been no difficulties and I understand that or general practice purposes they have been a boon.

Earlier in the year radio was installed in the cars of 9 elected midwives throughout the county operating through the mbulance service network. Urgent messages requiring the attend- nce of a midwife at a confinement are dealt with through ambul- nce control as part of the normal routine and the whole arrange- nents work very smoothly. As a result of the success of the cheme it is being further extended.

The Independent Television Authority has now built a radio tation at Ivy Hill, Egremont, the site earmarked by the County Council for providing their own station for the highways depart- ment and ambulance service. It has been agreed that the I.T.A. tation can also accommodate the highways and ambulance service equipment.

The Working Party of the Ministry of Health, which con- sidered the training and equipment of the ambulance service, issued its report. Standards of training, both pre-entry and post-entry, were recommended and it is encouraging to note that the syllabus for the Advanced Proficiency Certificate has already been covered by the lectures given by Consultants at both the Cumberland In-

firmary, Carlisle, and the West Cumberland Hospital, Hensingham during the courses in advanced first aid which have been held at these hospitals for the Cumberland Ambulance Service since 1963. The decision of the Health Committee to introduce such training courses in the early days of the directly provided service was forward looking. We now have a corps of highly trained ambulance men able to properly handle all the road accident cases they are called upon to deal with. On a very small number of occasions ambulance crews have felt it necessary to ask for the services of the resuscitation team based at the Cumberland Infirmary, Carlisle, but in nearly every case the injuries have proved fatal. Our experience shows that the concept of achieving the highest standard of training of ambulance crews thus minimising the calls upon the services of the resuscitation team is the correct one in the development in modern first aid treatment of road casualties.

The recommendations on equipment showed that, with minor modifications, all vehicles were already equipped to the required standard.

Stations

Negotiations are in hand to purchase land near the Cumberland Infirmary, Carlisle, to erect a station in place of the premises now in use at Bush Brow, Carlisle. The proposed station was included in the 1968/69 programme but, because of the economic situation, looks like being postponed for a year.

Staff

The only increase in staff, despite the increased mileage and patients, was a part-time ambulance man at Millom to undertake standby duties and afford some relief to the existing staff during their off duty periods. This arrangement works well.

Vehicles

During the year an order was placed for one traditional Bedford/Lomas ambulance. In accordance with this Authority's policy that any vehicle to be disposed of should first be offered to voluntary organisations before being offered for sale by public tender, the vehicle which is to be replaced will be offered to the newly formed Mountain Rescue Team at Millom at a nominal figure.

Following the decision of the Health Committee that a limited number of county-owned staff cars should be serviced by the maintenance staff at Distington Station, it was decided to select the cars of nurses in the Western Area. This experiment had been most successful but cannot be extended further without an increase in staff.

Training

Once again the drivers from East Cumberland each received a week's training in the Cumberland Infirmary, Carlisle. This training, which was on the lines advocated in the Ministry of Health's Working Party report, included periods in the Casualty Department, Orthopaedic Ward and Operating Theatre, with particular emphasis on lung ventilation. Similar arrangements are in hand for all West Cumberland personnel to receive training at the West Cumberland Hospital. I am greatly indebted to the Hospital Consultants who undertake the training and to the Hospital Management Committee for putting these facilities at our disposal.

There is no doubt that modern first aid treatment has become resuscitation of the patient; the control of severe haemorrhage and maintenance of an airway, with less and less emphasis on fractures. All our present training is designed with this in mind.

It is pleasing to report that a team from the Bush Brow Station, Carlisle, won the annual competition organised by the Carlisle Division of the St. John Ambulance Association in April, and a team from Distington won the award for the Best Ambulance Crew in the North of England Regional Competition held at Morpeth in May.

Hospital Car Service

Once again the 112 members of the Hospital Car Service have done an enormous amount of work on behalf of the ambulance service, covering this year just over 600,000 miles. There is no doubt this service is very much appreciated by all the patients and I am indebted to all those drivers who give up their time to do this valuable and rewarding service.

Mrs. Lee, County Director, Cumberland Branch of the British Red Cross Society, has kindly submitted the following comments:-

"1967 has been another very busy year for members of the Hospital Car Service whose numbers have increased to 114. They have dealt with just over 43,000 patients and covered nearly 600,000 miles during the year. This is surely an eloquent tribute to the enthusiastic way they do their work.

"During the year a short afternoon course for all drivers was held at the West Cumberland Hospital, Hensingham, the guest speaker being Dr. J. Kaminski, M.D., Consultant Geriatrician, West Cumberland, whose talk on the "Care of the Aged" was very much appreciated. The course was a success and was thoroughly enjoyed by the large number who attended.

"Finally I should once again like to extend to all car drivers my thanks for their kindness and attention they give to their patients in carrying out this valuable addition to the Ambulance Service."

Mrs. V. Raven, a Hospital Car driver who operates from Carlisle, comments:—

"First of all a word of appreciation for all the unfailing cooperation and couresy given by Mr. Butler, Mr. Hodgson and all the ambulance staff. It must be very difficult to fit everybody in to the best advantage, to meet economic requirements and find the right driver, to say nothing of the geographical difficulties. Personally I love the work and find it very rewarding and well worthwhile. I've found many friends among the patients I've driven, particularly the mental and spastic young people, though these need to be sandwiched with others as one needs balance.

"I find that patients like older drivers, and those who will take a sympathetic interest in them. A little laughter often helps. Also they like, as much as possible, the same driver.

"I realise that the waiting period is difficult but it isn't easy to get through a clinic in any set time, especially if extra tests and X-rays are needed, and I certainly think if we undertake to do this service we should realise this and be prepared to wait a reasonable time. However, one or two clinics could be better arranged so that patients, as well as drivers, could get away more quickly.

"One other matter, there is a great shortage of parking space for both ambulances and sitting cars and any extension would be welcomed, especially by Laurie the porter!

"In conclusion, may I say that when one sees the working of other ambulance stations one feels justly proud of Cumberland stations.

"Once again thank you and may we all be given strength to go on in this service so dear to us".

Mr. H. Fry, a Hospital Car driver from Workington, writes as follows:—

"Reviewing my activities on the Hospital Car Service in 1967 I would say that the task is a most rewarding one. Rewarding not in the sense of pecuniary benefits, rather in the satisfaction of performing a service that, albeit in a small way, is of benefit to patients and of some assistance to the County Ambulance Service.

"As one likes meeting people the work provides plenty of opportunity for this, also the occasional out of county trip gives added pleasure to a person like myself who likes driving.

"I would like to record my appreciation of the help and advice so freely given by the Officer in Charge and his team of controllers at the Ambulance Station, Distington, on the occasions when problems arise, their support and encouragement is of great value to all Hospital Car Service drivers.

"I hope I may be privileged for a long time to come".

I am grateful to Mr. R. M. Bompas, M.B.E., Group Secretary, West Cumberland Hospital Management Committee for his comment.

THE AMBULANCE SERVICE

"I think that most of the points with regard to the problems of satisfactory co-operation between the Hospital Service and the Ambulance Service were mentioned in Dr. Leiper's last report. It is however, very satisfactory to be able to say that the development of liaison and co-operaion between the two services during the last year has been excellent. This has meant that the number of individual points of difficulty has been reduced but, of course, no amount of co-operation will ever overcome the basic problem of always satisfactorily deciding between the conflicting needs of economy in the use of public money and the reasonable service to patients. However, the development of close liaison is sure to mean that the number of occasions when patients are dissatisfied with the decision taken is likely to be reduced.

"It would seem, from the point of view of the hospital, that the recent development in the hospital car service has made it possible to provide a service which much more nearly meets the needs of patients without incurring unreasonable expenditure. However, it does not seem unreasonable that where patients come from a distance, they should have to wait a little time at the hospital until a car load has been collected to take them home.

"Problems with regard to the discharge of patients so as to ease the work of the Ambulance Service are still met with, and there is still room for improvement in the day-to-day co-operation through the Hospital Transport Officer. However, plans are now in hand for re-organising the arrangements at the West Cumberland Hospital, which, it is hoped, will, by bringing the Transport Officer and the Ambulance Drivers more closely into association with those concerned with the admission and discharge of patients, enable an improved flow of information to the Ambulance Service and also arrange discharges in a planned way which will make the work of the Ambulance Service that much easier.

"Current trends in the Hospital Service in West Cumberland seems to be towards even greater centralisation and this must inevitably mean even greater demands on the Ambulance Service. It is thought, however, that the overall efficiency of running the Hospital Service will mean that the exra expendiure of public funds on the Ambulance Service will still be in the overall interest of the general public."

Mr. J. Butler, Superintendent, East Cumberland, submits the following comments:—

"During the past year all staff in East Cumberland have again completed a week's training at the Cumberland Infirmary and this has undoubtedly led to better relations between the hospital staff and members of this Service.

"The system of co-ordination which has been build up between the ambulance stations and hospitals has continued to improve; the day-to-day co-operation and co-ordination with Carlisle City Ambulance Service has never been better.

"The Hospital Car Service continues to be a very effective branch of the Service, as they deal with approximately 75% of all out-patients and most of the out-of-county journeys. I have nothing but praise for the work they do.

"During the year a number of district nurses have had radios installed in the cars operating on the ambulance frequency. This has been of great assistance to all concerned, but especially to patients urgently requiring the assistance of a midwife who may be out on her rounds and yet can be diverted to the patient's home.

"It is interesting to note that since 9th October, 1967, the number of road accidents recorded show a marked decrease in this area.

"All drivers in East Cumberland have an accident free record for 1967.

"A team from Bush Brow won the First Aid Competition organised by the Carlisle Division of the St. John Ambulance Brigade.

"I am sure it is appreciated that the staff at Bush Brow are required to work under difficult conditions as, apart from being housed in an old building, the demolition work carried out near the station has not made matters easier, and it is to their credit the vehicles are kept up to a high standard of cleanliness."

Mr. J. A. Mossop, Superintendent, West Cumberland, submits the following comments:—

"It is apparent that as time goes by, the role of the Ambulance Service is becoming more and more specialised due to the day and age in which we live, and I am, therefore, pleased to report the steady progress of training carried out by the ambulance crews. Over two-thirds are taking their studies in the Institute of Cerified Ambulance Personnel, after having gained a Higher Certificate in the St. John Ambulance Association examinations. We also receive enormous help and advice from the consultants and staff of the hospitals within our area.

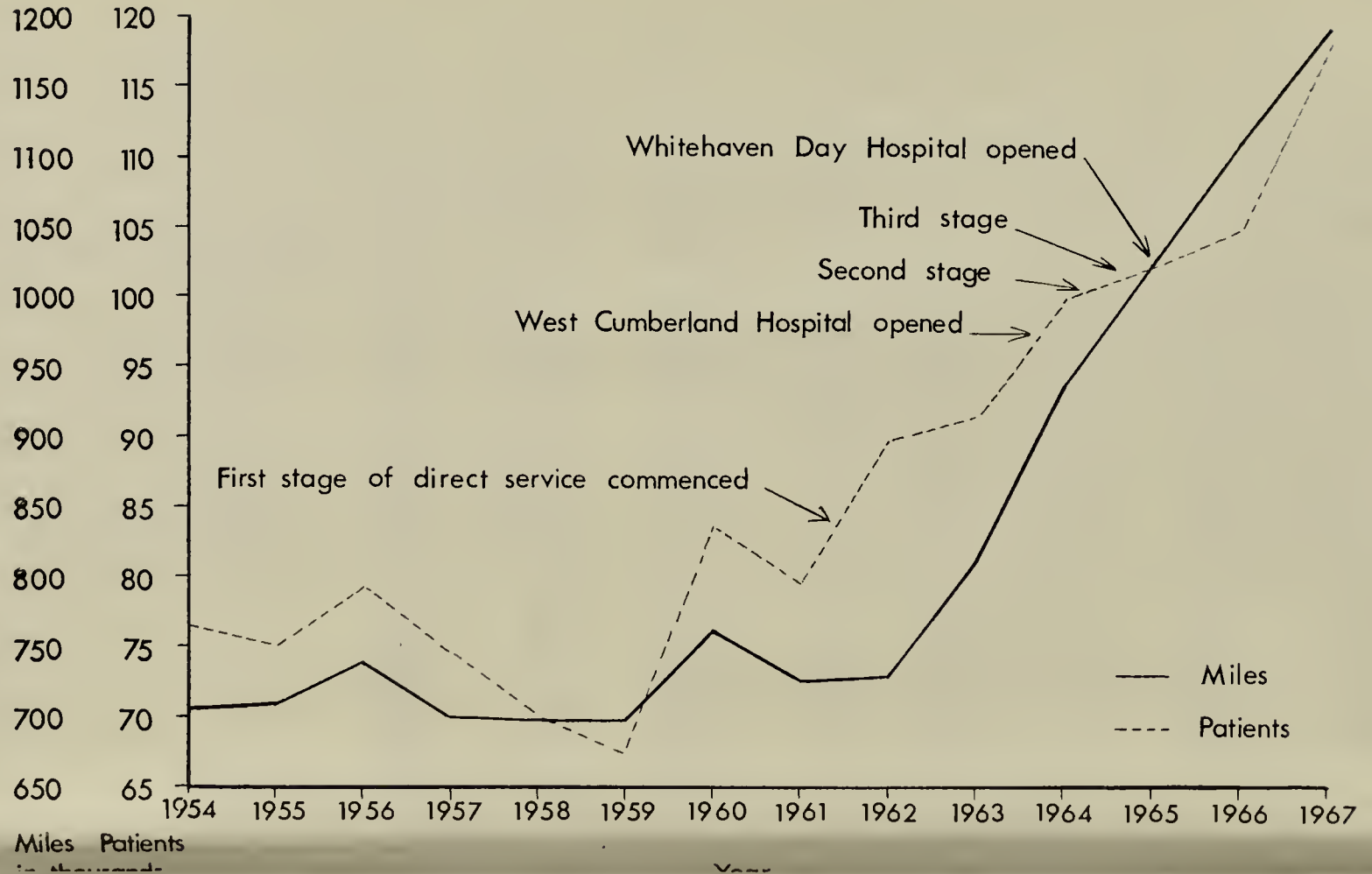
"The 'Air Lift' service was once again called upon to transfer a patient from the West Cumberland Hospital to the Royal Victoria Hospital, Newcastle, following injuries received in a road traffic accident.

"There has been, during the year, a marked lessening of the difficulties associated with the transport of geriatric patients, mainly due to the zoning and re-timing of clinics.

"The maintenance of midwives cars at the Distington Ambulance Station over the last twelve months has proved most successful and the vehicles are now showing the signs of regular care and maintenance.

"The installation of radio telephone in the midwives and doctors' cars in the Western and Southern areas have been undoubtedly progressive steps from which both the patient and service has benefitted."

		Ambulances		Sitting-Case Car Service		Hospital Car Service		Summary of all Services	
		Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage
1966	Agency Service ...	650	16377	3567	31304	843	22726	5060	70407
	Direct Service ...	56913	490814	—	—	43612	555512	100525	1046326
	TOTAL	57563	507191	3567	31304	44455	578238	105585	1116733
1967	Agency Service ...	608	15783	3858	30338	1196	32110	5662	78231
	Direct Service ...	70427	545641	—	—	42278	568467	112705	1114108
	TOTAL	71035	561424	3858	30338	43474	600577	118367	1192339
Increase or decrease compared with 1966 ...		+13472	+54233	+291	—966	—981	+22339	+12782	+75606



CUMBERLAND—GROWTH IN THE USE OF THE AMBULANCE SERVICE

CIVIL DEFENCE

Civil Defence Circular 1/1967, in revising the structure of the Civil Corps, also indicated that the Ambulance and First Aid Section should no longer be part of the Civil Defence Corps. Recruitment of this section was, therefore, permitted to slow down and training ceased as from 31st March.

On 31st July the Minister of Health set out his proposals in circular 13/67 for the organisation of Ambulance Services in War. This required the setting up of an Ambulance Emergency Reserve which is essentially a list of those drivers, male or female, who would be willing and able to turn out as drivers if an emergency was declared.

Advertisements asking for volunteers were inserted in local papers and met with a good response. Ex-members of the Ambulance Section of the Civil Defence Corps and of the Hospital Car Service were written to individually and, as a result, 184 people volunteered, some 50% of the total strength required.

Talks were held with the Civil Defence Officer regarding the need to co-ordinate training wherever possible. Visits and work at peace-time stations are also envisaged but guidance from the Ministry of Health regarding training is still awaited.

Three ex-Civil Defence ambulances, together with stretchers and blankets, have been taken over from the Civil Defence Officer for training purposes.

GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

Infectious Diseases

The table of Notified Infectious Disease overleaf shows a similar overall picture to that for the previous year. Again measles dominates the picture numerically and the measles vaccination scheme about to go into operation as this report is being written should substantially affect the figures for 1968.

The presence of dysentery in West Cumberland during 1967 will be observed from the table, with no doubt a good many more cases not notified for a variety of reasons. It cannot too often be stressed that the only effective control of such gastrointestinal infections is through scrupulous food hygiene and personal attention to hand washing before handling food.

Conditions associated with streptoccal infection continue to be represented in the table e.g. scarlet fever, puerperal pyrexia and erysipelas. The streptoccus is an organism which still demands considerable respect and vigilance lest acute rheumatic or kidney conditions should show signs of complicating an infection which in itself may be of no great severity.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES 1967

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentery	Meningococcal Infection	Acute Pneumonia	Acute Encephalitis Infective	Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Erysipelas	Food Poisoning	Tuberculosis Respiratory	Meninges and C.N.S.	Other T.B.	Puerperal Pyrexia	Ophthalmia Neonatorum
URBAN DISTRICTS—																		
Workington	1	16	—	198	10	—	—	—	—	—	—	1	1	4	—	3	2	—
Whitehaven	4	6	—	386	10	1	—	—	—	—	—	—	—	7	—	1	4	—
Cockermouth	—	11	—	3	—	—	—	—	—	—	—	—	—	—	—	—	1	—
Keswick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport	1	5	—	325	—	—	4	—	—	—	—	3	—	6	—	—	—	—
Penrith	8	—	—	119	4	—	1	—	—	—	—	1	—	3	—	—	1	—
RURAL DISTRICTS—																		
Alston	—	—	—	18	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Border	7	16	—	77	—	—	—	—	—	—	—	—	1	5	—	1	—	—
Cockermouth	8	4	—	125	1	—	—	—	—	—	—	1	—	5	—	1	1	—
Ennerdale	4	9	—	384	10	—	—	—	—	—	—	—	—	4	—	3	2	—
Millom	16	1	—	304	1	—	2	—	—	—	—	—	—	6	—	1	—	—
Penrith	3	3	—	227	1	—	1	—	—	—	—	—	—	3	—	—	—	—
Wigton	8	5	—	38	—	—	1	—	—	—	—	1	—	2	—	1	—	—
TOTAL FOR YEAR ...	60	76	—	2204	37	1	9	—	—	—	—	7	2	46	—	11	11	—
1966	184	83	—	1183	14	1	49	—	—	1	—	4	4	54	—	13	33	—
1965	76	17	—	3480	261	—	9	—	—	—	31	7	10	56	2	10	7	—
1964	119	152	—	1064	12	—	16	—	—	—	1	4	4	73	2	13	2	2
1963	23	119	1	1836	50	5	22	—	—	1	—	4	31	76	1	12	12	—
1962	35	39	2	2485	149	6	40	—	1	—	—	4	40	94	1	12	33	—
1961	57	72	4	2204	149	—	85	—	—	—	—	10	15	80	—	15	21	—

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights and Measures for the following report:—

FOOD AND DRUGS ACT, 1955

Summary of work done under the above Act during the year ended 31st December, 1967

Total Samples Obtained		Genuine		Unsatisfactory	
Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
441	234	427	229	14	5
675		656		19	

During the year 675 samples were obtained of which 441 were milk and 234 were various foods and drugs. Although the number of samples taken was limited by the cost of analyses, an endeavour was made to cover as wide a range of foodstuffs as possible. The samples of drugs consisted chiefly of proprietary medicines and normal drugs available to the public. Compared to the vast range of foods and the many different brands on the market, the number of samples taken on behalf of this authority was small. However, as other local authorities throughout the country were also engaged on sampling duties, it is fairly safe to assume that the majority of foodstuffs were sampled from time to time, affording some degree of protection to the consumer. On the whole the manufacturers complied with the various regulations made under the Food and Drugs Act. With so must competition a manufacturer cannot afford the adverse publicity which might result from the production of a foodsuff of unsatisfactory quality.

All the samples of food and drugs and 23 of the milk samples were submitted to the Public Analyst. The remainder of the milk samples were tested by the Sampling Officers.

With regard to the milk samples sent to the Analyst, where the samples were known to be farm bottled, they were tested for penicillin in addition to the ordinary compositional analysis. No antibiotics were detected.

The average quality of milk samples tested by the Sampling Officers, including 11 below standard, was 3.6% fat and 8.6% solids-not-fat compared to the presumptive standard of 3.0% and 8.5% respectively.

Under the national scheme for testing foodstuffs for residues of insecticides and pesticides, this authority submitted samples of bread (white and wholemeal), carrots, milk, eggs, lettuce, cheese, tomatoes, plums and pears. The results of the tests were satisfactory.

The percentage of unsatisfactory samples, of the total number obtained, was 2.8 compared to 5.2 the previous year. Taken separately the unsatisfactory milk samples decreased from 5.8% to 3.2% and the percentage of unsatisfactory articles other than milk decreased from 4.0 to 2.1.

The unsatisfactory samples were dealt with as follows:—

Milk:

Two samples of milk taken at a farm contained 10.3% and 13.3% of added water. These samples were taken following a complaint from the dairy which received milk from the producer. The farmer was prosecuted and fined £5 with £8/17/- costs.

Another producer was also prosecuted in respect of milk containing extraneous water and was fined £10 plus an advocate's fee of £10/10/- and £8/5/- costs.

The milk samples tested by the Sampling Officers and found to be unsatisfactory included three samples, from one producer, which were slightly below standard in non-fatty solids but a freezing point test indicated that the deficiency was not due to

ıe presence of extraneous water but that the milk was of poor uality. A further sample taken later showed that the quality had nproved. The remaining unsatisfactory samples were only slightly elow standard and further samples taken later were satisfactory.

Unsatisfactory food and drugs other than milk:

The Analyst expressed the opinion with regard to a sample f fruit flavoured lollies that the description was misleading as the rticle did not contain fruit or fruit juice. The matter was taken p with the manufacturers and they stated they would have new vrappers printed and omit any reference to fruit.

No further action was taken in respect of a sample of Yorkhire pudding which had a very slight degree of rancidity. This night have been due to the food having been in a frozen food abinet and by the time the sample was analysed deterioration ould have begun.

A sample of aspirin spirit liniment was deficient in menthol. Owing to the volatile nature of menthol the Analyst requested an unopened bottle of the liniment for comparison with the analysis of the original sample. The results were very similar and confirmed that the deficiency in menthol in the first sample was not due to accidental evaporation. The atention of the manufacturers was drawn to the deficiency.

One article of food which was not of genuine quality was a "buttered teacake" which was in fact spread with margarine. Proceedings were instituted against the seller who was fined £10.

Complaints of unsatisfactory food other than articles submitted for analysis:

Several complaints were received from members of the public concerning unsatisfactory food of which the following are examples:

A loaf of bread contained pieces of rusty wire and a fine of £50 was imposed on the firm of bakers. Another loaf of bread contained a cockroach for which the bakers were fined £10 with £6/6/- costs.

Enquiries were made about a potato crisp which was stained purple. It was thought the crisp might have come from a potato intended for stock feeding, such potatoes being marked with a purple dye. It was established that the colour in the crisp was due to a natural pigment called "anthocyanin" which develops alongside chlorophyll in potatoes which have turned green owing to exposure to light. The anthocyanin, which is quite harmless, could possibly have developed during the cooking and might not have been visible in the raw potato.

RURAL WATER SUPPLIES AND SEWERAGE ACTS, 1944-61

Water Supplies

Only three very small mains extension schemes were submitted for observations during the year and these are listed in the following schedule of schemes. This is a similar position to last year.

Grants

Notification of grant in respect of 8 water supply schemes was received, these being small schemes all costing less than £2,500 each.

In each case the County Council paid a grant equivalent to the Ministry's.

Sewerage Schemes

Six new Sewerage and Sewage Disposal schemes were submitted as against three in the previous year.

Two were from Cockermouth Rural District, two from Border Rural Disrict and two from Penrith Rural District and details are set out in the attached schedule.

Grants

Four sewerage grants were notified and the County Council decided to make equivalent grants in all cases.

Technical Assistance for District Councils

The scheme whereby the County Engineer undertakes the preparation and supervision of sewerage schemes for District Councils has continued and schemes have been prepared on behalf of:

Border Rural District Council—Smithfield Sewerage Scheme with further requests from Penrith Rural District Council for assistance with their Greystoke scheme and drainage from a proposed Motorway Service Area at Southwaite.

Water Schemes

Scheme Submitted by	Name of Scheme	General Outline	Est. or Final Cost	Remarks
South Cumberland Water Board.	Mains Extension, Santon Bridge.	Extension to Millom Northern Parishes Water Scheme.	£347	Approved as sound and adequate.
Eden Water Board	Wreay Mains extension	Extension of mains to supply properties at Berkthwaite.	£1,500	Approved as sound and adequate.
West Cumberland Water Board.	Rosthwaite Mains extension	Mains extension to serve a further 9 properties at Rosthwaite.	£300	Approved as sound and adequate.

Sewerage Schemes

Scheme Submitted by	Name of Scheme	General Outline	Est. or Final Cost	Remarks
Cockermouth Rural District Council	Seatoller Sewerage and Sewage Disposal Scheme.	A scheme to lay 640 lineal yards of 6" diameter sewer to drain the village by gravity to new sewerage disposal works.	£13,380	Approved as sound and adequate subject to amendments to sludge beds.
Border Rural District Council.	Smithfield Sewerage Scheme.	To lay sewers to serve existing houses and provide new treatment works.	£22,800	Approved as sound and adequate.

Sewerage Schemes—Continued

Border Rural District Council.	Cargo Sewerage and Sewage Disposal Scheme.	Scheme for the improvement of the sewerage and Sewage Disposal facilities at Cargo.	£44,893	Approved as sound and adequate.
Cockermouth Rural District Council	Broughton Craggs Sewerage Scheme	12″ diameter relief sewer of 720 yards as a first instalment of a major scheme.	£8,700	Approved as an adequate short term solution only to be followed by the full reconstruction of the treatment work.
Penrith Rural District Council	Melmerby Sewerage and Sewage Disposal Scheme	To provide sewerage and disposal works for the village of Melmerby.	£27,800	Approved as sound and adequate.
Penrith Rural District Council	Motherby and Penruddick Sewerage Scheme	Sewerage of the villages of Motherby and Penruddock.	£37,650	Approved as sound and adequate.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1967

(N.B.—Corresponding figures for 1966 are shown in brackets)

		Alston R.D.C.	Border R.D.C.	Cocker-mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	White-haven Boro'	Working-ton Boro'	Cocker-mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.	County Total
	Population — 1951	2,327	29,845	20,455	29,676	13,428	11,723	23,733	24,624	28,891	5,235	4,868	12,180	10,492	205,847
	(Census) — 1961	2,198	29,647	20,966	30,870	15,094	11,606	21,868	27,541	29,552	5,827	4,765	12,393	10,927	223,202
A 1	Total number of occupied dwelling houses in the district:	832	9,243	7,124	10,194	4,564	3,715	7,523	8,167	9,480	2,339	1,594	4,173	3,666	72,614
		(831)	(9,172)	(7,074)	(9,907)	(4,607)	(3,642)	(7,480)	(8,074)	(9,414)	(2,262)	(1,590)	(4,226)	(3,607)	(71,886)
2	Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings:	1	—	5	46	41	20	26	30	6	7	3	52	16	253
		(1)	(—)	(7)	(143)	(34)	(10)	(34)	(60)	(3)	(8)	(—)	(38)	(4)	(345)
3	Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost: ...	13	276	109	263	229	70	258	25	1,500†	110	—	54	90	2,997
		(13)	(315)	(159)	(319)	(251)	(75)	(288)	(10)	(NK)	(115)	(—)	(80)	(96)	(1,721)
4	Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit:	45	480	NA	NK	200	390	1,030	NK	2,500§	17	50	52	150	4,914
		(50)	(490)	(NA)	(NK)	(197)	(400)	(1,074)	(20)	(NK)	(17)	(50)	(55)	(20)	(2,373)
5	Number of houses found to be overcrowded:	4	12	2	—	3	7	1	—	—	—	—	—	5	34
		(5)	(15)	(2)	(—)	(6)	(10)	(—)	(—)	(NK)	(—)	(—)	(—)	(3)	(41)
B	WAITING LISTS														
	Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above:	56	206	507	285	161	88*	488	578	669	215	89	359	288	3,989
		(38)	(190)	(486)	(472)	(191)	(88*)	(470)	(526)	(700)	(173)	(54)	(323)	(275)	(3,986)
C	NEW DWELLINGS COMPLETED DURING THE YEAR														
1	By or for the Council—														
	For aged persons	—	9	10	40	13	12	20	—	9	—	—	—	—	113
		(—)	(8)	(6)	(37)	(15)	(—)	(14)	(2+16)	(13)	(6)	(—)	(—)	(—)	(117)
	For aged persons grouped with welfare facilities	—	—	—	—	—	—	10	—	—	—	—	—	—	10
		(—)	(—)	(—)	(22)	(—)	(—)	(—)	(—)	(24)	(—)	(—)	(—)	(—)	(46)
	For agricultural workers	—	—	—	—	—	—	—	—	—	—	—	—	—	—
		(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)
	General purpose dwellings	—	8	—	206	—	—	4	66	34	48	—	—	3	369
		(—)	(33)	(14)	(42)	(—)	(—)	(52)	(112)	(71)	(—)	(18)	(20)	(49)	(411)
2	Private building:	1	92	47	55	23	22	21	40	48	29	7	23	13	421
		(2)	(98)	(43)	(54)	(11)	(22)	(38)	(62)	(45)	(47)	(23)	(49)	(13)	(507)
	Total of 1 and 2 ...	1	109	57	301	36	34	55	106	91	77	7	23	16	913
		(2)	(139)	(63)	(155)	(26)	(22)	(104)	(192)	(153)	(53)	(41)	(69)	(62)	(1,081)
D 1	Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants): ...	10	50	53	58	43	52	146	25	80	15	14	44	20	610
		(14)	(69)	(84)	(65)	(30)	(46)	(52)	(18)	(75)	(4)	(9)	(30)	(17)	(513)
2	Number of houses for which grants were approved:	10	42	50	87	39	55	39	24	86	15	14	44	19	524
		(9)	(74)	(83)	(64)	(30)	(44)	(51)	(17)	(72)	(4)	(9)	(30)	(12)	(499)
3	Number of houses where improvements were carried out and grants paid;	7	54	71	54	34	33	52	17	56	8	10	33	11	440
		(11)	(65)	(66)	(58)	(34)	(35)	(57)	(17)	(38)	(3)	(14)	(—)	(15)	(413)
4	Number of houses purchased or taken over by the Council with a view to improvement or conversion:	—	8	—	—	—	—	—	—	—	—	—	—	—	8
		(—)	(26)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(26)
5	Number of houses improved by the Council—														
	(i) with grant	—	65	8	2	1	—	1	—	17	—	—	—	2	96
		(—)	(42)	(—)	(48)	(—)	(—)	(—)	(1)	(—)	(—)	(—)	(—)	(1)	(92)
	(ii) without grant	—	8	—	—	—	—	—	—	3	—	—	—	—	11
		(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)
E	HOUSING PROGRAMME FOR ENSUING YEAR—														
1	Dwellings to be built by or for the Council—														
	For aged persons	—	12	—	17	4	25	76	—	100	—	—	10	10	254
		(—)	(12)	(9)	(40)	(13)	(22)	(25)	(2+—)	(8)	(—)	(—)	(—)	(—)	(131)
	For aged persons grouped with welfare facilities	—	—	—	—	10	14	—	—	—	—	—	22	21	67
		(—)	(—)	(—)	(—)	(10)	(—)	(10)	(—)	(—)	(—)	(—)	(20)	(—)	(40)
	For agricultural workers	—	—	—	—	—	—	—	—	—	—	—	—	—	—
		(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)	(—)
	General purpose dwellings	8	22	—	228	8	10	47	26	63	—	55	30	40	567
		(2)	(8)	(—)	(310)	(6)	(8)	(24)	(70)	(25)	(48)	(42)	(6)	(10)	(599)
2	Private building	2	NK	53	50	20	30	35	45	100	30	10	12	30	427
		(4)	(NK)	(45)	(50)	(26)	(20)	(45)	(50)	(100)	(25)	(34)	(35)	(20)	(450)
	Total of 1 and 2 ...	10	34	53	295	42	79	158	71	263	30	65	74	101	1,315
		(6)	(20)	(54)	(400)	(55)	(50)	(104)	(122)	(133)	(73)	(72)	(61)	(30)	(1,220)

* Old People only. + Disabled.
† Should be dealt with by demolition within a 15 year period.
§ Qualify for grant aid within a 10 year period.

APPENDICES

I. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.

II. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.

III. Mass Radiography.

IV. County Council Clinics.

APPENDIX I

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland in 1967 by Dr. R. Hambridge

There has been no change in the pattern of Chest Clinic work in West Cumberland during 1967 except that the Mass X-ray Unit has now ceased to function as a mobile unit and consists of two static units stationed at Workington Infirmary and West Cumberland Hospital respectively.

New Cases.

The continued downward trend in notification of new cases is still apparent. Compared with last year's 53 new cases 41 new cases were notified in 1967, including two deceased, of whom one was diagnosed posthumously. Of these new cases 17 were bacteriologically confirmed as infectious.

Tuberculosis Register.

The downward trend under this heading also continues though the total on the Register remains above the 1,000 mark at 1,164 compared with 1,417 in 1966. Of this total 1,099 were respiratory and 65 were non-respiratory cases of tuberculosis.

Deaths.

5 deaths from tuberculosis occurred during this year, including the one which was diagnosed posthumously.

Contacts of Cases of Tuberculosis.

In addition to 114 old contacts who were checked routinely 144 contacts attended the Mass X-ray Units, none of whom were notified. 146 were skin tested and this produced only one positive result and this was the only notification among the contacts.

Prophylactic vaccination wih B.C.G. was carried out on 397 contacts (423 in 1966).

Mass Radiography Units.

The results of the two static units in Whitehaven and Workington with the corresponding figures for 1966 are given below:—

Total number of examinees	8,054	(8,349)
Number referred by doctors	2,357	(2,19)

Number of persons found to be suffering from:—

(a) Active tuberculosis	12	(11)
(b) Inactive tuberculosis requiring supervision	21	(51)
(c) Bronchiectasis	12	(10)
(d) Neoplasm	17	(7)
(e) Sarcoidosis	1	(1)
(f) Pneumoconiosis	14	(13)
(g) Cardiac conditions	8	(9)

Seven of the active cases of tuberculosis and sixteen of the cases of neoplasm were found in patients referred by doctors.

APPENDIX II

Annual Report on Tuberculosis and other chest diseases in East Cumberland in 1967 by Dr. W. H. Morton

Introduction

The figures for tuberculosis in 1967 show a slight increase in this area. The number of new cases of pulmonary tuberculosis notified was 38, compared to 35 in 1966, whilst the total number of notified cases on the actual chest centre register was 432, compared to 427 at the end of 1966; the total number of cases of tuberculosis under supervision at the chest centre remains at 1,013. Of the 38 new cases of pulmonary disease found in 1967 only 14 were confirmed bacteriologically.

The number of new cases of bronchial carcinoma for 1967 unfortunately again shows an increase, the new figure being 76 compared to 67 for 1966. Of the new cases only three were accepted for surgery. The cytotoxic drug therapy trial still continues although no new cases from now on are being included in this trial.

Chronic bronchitis, with or without emphysema, and asthma remain the two commonest conditions seen in new patients at the centre. Only 19 new cases of bronchiectasis were seen during 1967. Altogether 291 cases of bronchiectasis are under active supervision and are treated by postural drainage and intensive physiotherapy. During 1967 these cases of bronchiectasis alone were responsible for 1,500 patient attendances for treatment by the physiotherapist.

Tuberculosis

Table 1 shows the total number of new cases of pulmonary tuberculosis for England and Wales and for the area of East Cumberland, for 1967 and the preceding five years:—

Table 1

Year	England & Wales	East Cumberland
1962	17,973	23
1963	16,355	18
1964	15,026	25
1965	13,552	14
1966	12,461	11
1967	11,090	23

The number of chest beds available during the year with the number of discharges for 1966 and 1967 are shown in Table 2:—

Table 2

Hospital	Beds available	No discharged in 1967	No. discharged in 1966
Ward 18, Cumberland Infirmary	14	263	267
Longtown Hospital ...	26	135	146
Blencathra Hospital ...	11	43	27

The regimen of therapy in pulmonary tuberculosis remains as before; no cases of tubercle have been submitted to surgery during the year.

Contact examinations have continued as in previous years; all contacts under 21 are Mantoux tested, and 741 such tests were carried out during the year 1967.

Twenty years ago the Mantoux test and its interpretation appeared straightforward as a positive reaction meant previous infection with the tubercle bacillus, and with a very few exceptions no reaction meant the reverse. Within recent years, however, a difficulty has been recognised in that atypical myco-bacteria and avian tubercle bacilli give rise to reactions usually of lower intensity. This difficulty has been recognised abroad for some time but in England it was thought to be of little significance. However, surveys in the last few years have changed this attitude, and with growing awareness that reactions due to these atypical organisms can arise, the interpretation of the Mantoux test has become more complex. A strong positive reaction, however, remains possibly the best index to the amount of tuberculosis in the community, and can still be taken, I think, to indicate previous infection or previous vaccination with B.C.G. The difficulty usually arises in the weaker reactions. Mantoux testing after B.C.G. vaccination is no longer necessary in every case, and we only do an occasional one.

The question of chemoprophylaxis has also come to the fore in recent years. Extensive trials have been conducted abroad, particularly in the U.S.A. but the methods have not been so widely adopted in this country. The drug used in these trials has usually been Isoniazid.

The United States of America National Tuberculosis Association has within recent months made recommendation that chemoprophylaxis should be mandatory for certain groups of patients. These groups include (1) previous patients who have had inadequate therapy; (2) patients with a positive Mantoux test and radiologically healed disease; (3) contacts with a markedly positive Mantoux test and reactors under 21; (4) known convertors in all age groups; (5) patients with a positive Mantoux test who are on steroid therapy, or those undergoing a gastrectomy, or those suffering from instable diabetes. They also advise that pregnant women with inactive tubercle should be treated chemopraphylactically and that children developing measles and whooping cough should have Isoniazid for 8 weeks, if they have been treated for tuberculosis previously.

The actual dividing line between chemoprophylaxis and actual therapy in tuberculosis is not easily defined. Tuberculous disease, as is well known, comparatively rarely follows infection; it does, however, seem sensible to prescribe therapy for known convertors and strongly positive Mantoux reactors in the early age groups. We already do this. Seldom, however, do we prescribe Isoniazid alone but usually combine this with Paramisan; other cases we treat on their merits.

It is worth while commenting on the marked decline in bovine tuberculosis in the country since the attested herd scheme started in 1935. In a fairly recent survey in South West Scotland only 0.28% of the pulmonary cases were found to be infected by the bovine strain, and it is probable that even these patients had a recurrence of an old latent infection.

Table No. 3 shows the number of B.C.G. vaccinations carried out in 1967.

Table 3

	Male	Female	Total
Carlisle City	55	48	103
East Cumberland ...	64	59	123
North Westmorland ...	7	11	18
Hospitals	3	47	50
	129	165	294

Bronchial Carcinoma

Bronchial carcinoma still carries a very poor prognosis and as indicated previously only a very small number of cases—three—were accepted for surgery. Unfortunately the disease may be well advanced before unusual symptoms develop to make the patient seek medical advice. Unfortunately, again there is no easy method for making an early diagnosis. Even when a diagnosis is made on radiological evidence, bronchoscopy is necessary to secure positive histological evidence. The examination of sputum itself for malignant cells is not very rewarding as cells are found in such a small degree of cases.

The number of new cases of bronchial carcinoma coming to our notice for 1967 are:—

East Cumberland	Males	Females	Total
New cases	32	9	41
Admitted for surgery	1	--	1

Other Chest Conditions

Most cases of asthma and chronic bronchitis, with or without emphysema are fully investigated and full use is made of spirometry readings. Acute respiratory distress in many of these patients is of the nature of an emergency and treatment can be difficult. Intensive physiotherapy remains the mainstay of routine treatment and indeed most of the physioherapist's time is devoted to asthmatics and chronic bronchitics.

1967 would have been the exception had we not had the usual number of cases of 'Farmer's Lung', the vast majority of which cleared satisfactorily without any treatment.

Of the cases of sarcoidosis seen through the year, approximately half required steroid therapy, and there has been no deaths from this condition.

APPENDIX III

MASS RADIOGRAPHY

REPORT ON THE WORK OF THE MASS RADIOGRAPHY UNIT DURING 1967

(NOTE: Figures given in brackets throughout the report relate to the corresponding figures for 1966)

17,592 (18,556) persons were examined by the Units during the year and of these 688 (798) were referred for clinical examination.

Table 1 shows the number of abnormalities revealed during 1967, throughout the whole of the Special Area.

TABLE 1

	No. of Cases found		Percentage of total examined	
ABNORMALITIES REVEALED				
(1) Non-tuberculous conditions:				
(a) Bronchiectasis ...	32	(30)	.18	(.16)
(b) Pneumoconiosis ...	19	(13)	.11	(.07)
(c) Neoplasm	33	(36)	.18	(.19)
(d) Cardiovascular conditions	45	(43)	.25	(.23)
(e) Miscellaneous requiring investigation ...	4	(13)	.02	(.07)
(2) Pulmonary tuberculosis				
(a) Active	21	(20)	.12	(.11)
(b) Inactive requiring supervision	33	(69)	.19	(.36)

Table 2 gives the analysis of the work of the mobile units vided into the East and West Cumberland areas:—

EAST CUMBERLAND									WEST CUMBERLAND								
Source of examination	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis requiring supervision	Bronchiectasis	Neoplasm	Pneumoconiosis	Cardiac conditions	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis requiring supervision	Bronchiectasis	Neoplasm	Pneumoconiosis	Cardiac conditions
Doctors' cases	—	—	—	—	—	—	—	—	38	—	—	—	—	—	—	—
Contact cases	905	12	—	1	—	—	—	3	144	2	—	—	—	—	1	—
Students	—	—	—	—	—	—	—	—	3	—	—	—	—	—	—	—
School staff	94	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
General public	—	—	—	—	—	—	—	—	1,651	23	1	1	—	—	2	2
Surveys	977	23	1	1	—	—	2	3	—	—	—	—	—	—	—	—
TOTALS	1,976	35	1	2	—	—	2	6	1,836	25	1	1	—	—	3	2

Table 3 gives an analysis of the work of the Static Unit i
Carlisle, the Static Unit at the West Cumberland Hospital an
the work of the mobile unit while operating in a static rol
at Workington Infirmary.

TABLE 3

Source of Examination	STATIC UNITS														WHITEHAVEN										WORKINGTON									
	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Cardiac Conditions	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Pneumoconiosis	Cardiac Conditions	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Pneumoconiosis	Cardiac Conditions	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Pneumoconiosis	Cardiac Conditions
Doctors' cases	2,719	236	5	7	17	12	21	1,041	76	3	5	1	10	8	3	1316	94	4	8	6	6	—	1
Contast cases	59	3	1	—	—	—	—	74	—	—	—	—	—	—	—	85	2	—	—	—	—	—	...
General public	2,335	63	1	1	2	4	5	1,220	25	1	2	1	1	2	1	790	21	1	—	5	—	—	—
Hospital Out-patients	—	—	—	—	—	—	—	1,742	49	—	2	—	—	4	3	537	19	—	2	—	—	—	—
Employees	613	14	—	1	—	—	2	811	18	3	2	—	—	—	—	283	5	—	—	—	—	—	—
Students	—	—	—	—	—	—	—	83	1	—	—	—	—	—	—	72	—	—	—	—	—	—	...
TOTALS	5,726	316	7	9	19	16	29	4,971	171	7	11	2	11	14	7	3083	141	5	10	11	6	—	1

Table 4 gives the relative figures as between East and West Cumberland for the past eight years.

Year	EAST CUMBERLAND								WEST CUMBERLAND							
	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
1960 ...	21	11	19	120	19	2	18	21	7	23	9	52						
1961 ...	20	11	24	144	23	4	13	20	5	24	10	42						
1962 ...	24	14	25	71	22	2	12	63	9	18	19	60						
1963 ...	17	4	21	67	27	6	8	58	3	23	18	37						
1964 ...	13	7	16	47	22	1	7	36	7	10	5	14						
1965 ...	10	15	9	40	12	—	12	50	8	9	1	8						
1966 ...	9	15	29	34	20	—	11	52	7	8	10	13						
1967 ...	8	11	16	35	19	2	13	22	17	10	13	17						

Table 5 refers solely to the area covered by the East Cumberland Hospital Management Committee and shows the number of new cases of neoplasm discovered.

TABLE 5

	1960	1961	1962	1963	1964	1965	1966	196
No. of cases of neoplasm seen at chest centre	54	64	60	74	80	54	67	76
No. discovered by M.M.R.	19	24	25	21	16	9	29	16

Comments

1968 sees the end of an era in the Mass Radiography Service in this area. The mobile unit is being withdrawn and further mass radiography work in the area will be concentrated at the three Static Units in Carlisle, Whitehaven and Workington. Further surveys will be carried out in the area by calling on a general mobile van based at Newcastle. Such an arrangement will not prejudice our work and should indeed go smoothly.

The operations of the Static Units will continue. The units at both Whitehaven and Workington are situated within the environs of the local general hospitals. The Carlisle unit is situated at 72, Warwick Road. Both main hospitals in Carlisle are not central and experience has shown that patients referred by their own doctors, even from the outlying areas such as Penrith and Wigton, find it comparatively easy to get to Warwick Road. There is, however, the problem of staffing this unit as it is some distance from the chest centre, but it is hoped that suitable arrangements can be made so that the work can continue uninterruptedly.

Consequent on the withdrawal of our own mobile unit, Mr. Ritchie, who has been Organising Secretary to the Service since its inception, is being transferred to Newcastle. I must place on record here my deep personal appreciation of Mr. Ritchie's service during these years. Not only has he been a most co-operative and agreeable colleague, but his personal qualities have helped very

nsiderably in arranging surveys with firms and employers and ıer outside bodies. In the early 1950's when we first started : Mass Radiography Service, tuberculosis was still rampant and rveys meant considerable hard work on the part of us all. It is exaggeration to say that Mr. Ritchie, as Organising Secretary, led a key role and contributed greatly to the success of our service.

I have also to record the impending retirement of Miss Hind. iss Hind was the first Mass Radiography clerk to be appointed the unit and later became the doctor's secretary. She has ven very loyal and efficient service and we wish her well in her tirement.

This will be the last of the Mass Radiography reports for is area; in future the figures for the Static Units will form part the statistics for the local chest centres.

APPENDIX IV

County Council Clinics

Centre	Address	Clinic Services
Alston ...	Cottage Hospital, Alston	Child Welfare, Dental, Family Planning, Chiropody.
Anthorn ...	Welfare Office, ... Anthorn	Child Welfare, Vaccination and Immunisation.
Aspatria ...	St. Mungo's Park, Aspatria	Ante-Natal, Child Welfare, Dental, Speech Therapy, Orthopaedic, Vaccination and Immunisation.
Brampton ...	Union Lane, ... Brampton	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Vaccination and Immunisation.
Broughton ...	Nurse's House, ... Little Broughton	Child Welfare.
Carlisle ...	14 Portland Sq., ... Carlisle	Child Guidance, Dental, Ophthalmic, Orthoptic, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Cleator Moor ...	Ennerdale Rd, ... Cleator Moor	Ante-Natal, Child Welfare, Chiropody, Dental, Vaccination and Imunisation, Cervical Cytology.
Cockermouth ...	Harford House, ... Cockermouth	Relaxation, Child Welfare, Chiropody, Dental, Ophthalmic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Crosby (Maryport) ...	Nurse's House, ... 6 Parkside, Crosby, Maryport	Child Welfare.
Dalston ...	Victory Hall, ... Dalston	Child Welfare, Vaccination and Immunisation.
Dearham ...	Nurse's House, ... Central Road, Dearham.	Child Welfare.

Centre	Address	Clinic Services
Egremont ...	St. Bridget's ... Lane, Egremont	Ante-Natal, Child Welfare, Chiropody, Dental, Vaccination and Immunisation, Speech Therapy.
Frizington ...	Council ... Chambers, Frizington	Ante-Natal, Child Welfare, Vaccination and Immunisation.
Houghton ...	The Village ... Hall, Houghton	Child Welfare, Vaccination and Immunisation.
Hunsonby ...	The Village ... Institute, Hunsonby	Child Welfare, Vaccination and Immunisation.
Keswick ...	13-15 Bank St., ... Keswick	Relaxation, Child Welfare, Dental, Ophthalmic, Speech Therapy, Vaccination and Immunisation.
Longtown ...	Esk Street, ... Longtown	Child Welfare, Dental, Orthopaedic Vaccination and Immunisation.
Maryport ...	24 Selby Terrace, Maryport	Ante-Natal, Child Welfare, Child Guidance, Speech Therapy, Vaccination and Immunisation, Cervical Cytology (at Surgery).
Millom ...	18, St. George's... Road, Millom	Ante-Natal, Child Welfare, Child Guidance, Dental, Speech Therapy, Vaccination and Immunisation, Cervical Cytology, Family Planning
Nenthead ...	Doctor's ... Surgery.	Child Welfare.
Penrith ...	Brunswick ... Square, Penrith	Ante-Natal, Child Welfare, Dental, Family Planning, Hearing Therapy, Vaccination and Immunisation, Psychiatric, Speech Therapy, Orthopaedic, Orthoptic, Cervical Cytology.
Scotby ...	The Village Hall, Scotby	Child Welfare, Vaccination and Immunisation.

Centre	Address	Clinic Services
Seascale ...	Gosforth Road, ... Seascale	Child Welfare, Dental, Chiropody, Vaccination and Immunisation.
Seaton ...	Miners' Welfare ... Hall,' Seaton	Child Welfare, Vaccination and Immunisation.
Skinburness ...	R.A.F. Hut ...	Child Welfare.
Thornhill ...	Community ... Centre, Thornhill.	Child Welfare.
Thursby ...	The Church Hall, Thursby	Child Welfare, Vaccination and Immunisation.
Wetheral ...	The Village Hall, Wetheral	Child Welfare, Vaccination and Immunisation.
Whitehaven ... Flatt Walks	Flatt Walks, ... Whitehaven	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Schools, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Mirehouse ...	Dent Road, ... Mirehouse, Whitehaven	Ante-Natal, Child Welfare, Dental, Vaccination and Immunisation.
Woodhouse	Woodhouse, ... Whitehaven	Ante-Natal, Child Welfare, Vaccination and Immunisation.
Wigton ...	Birdcage Walk, ... Wigton	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Workington ...	Park Lane, ... Workington	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, School, Speech Therapy, Cervical Cytology.
Salterbeck ...	Holden Road, ... Salterbeck, Workington	Ante-Natal, Child Welfare, Dental, Cervical Cytology, Vaccination and Immunisation.